



**GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES**
- 0 -
DEPARTMENT OF HEALTH
1303 HOSPITAL GROUND, SUITE 10, ST. THOMAS, U.S. VI. 00802

**VIRGIN ISLANDS
BOARD OF MEDICAL EXAMINERS**

**(340) 774-0117
(340) 776-8311
EXTS. 5074/5078**

Dear:

The Board of Medical Examiners received your request for information pertaining to licensure procedures to practice medicine in the U.S. Virgin Islands.

All applicants are required to take a state board (**SPEX**) computerize examination in the U.S. Virgin Islands, which is given on St. Croix twice a year, May and November. After successfully passing this examination, you are required to do an oral interview with the Board to complete this process.

All applicants are required to submit their background credentials to the Federation Credentials Verification Service (FCVS).

FCVS provides a permanent central depository for documents, which represent the core credentials of any physician. FCVS will conduct a primary source verification of those documents at the time they are submitted, and the physician will not be required to re-verify that information even if he or she moves to another state. Currently, 56 state medical boards accept FCVS documents in lieu of the applicant providing new original source documents. The U.S. Virgin Islands and other state medical boards require all applicants to use FCVS for verification of their credentials.

You should first complete the FCVS application package, which can be obtained by going to www.fsmb.org. This process takes a minimum of 8 to 12 weeks. The V.I. Medical licensure application may also be down loaded using this same website. After completing the V.I. application, it should be mailed directly to the above address.

Be sure to read the instructions carefully and fill out the application completely. Do not omit any information. If you have questions about the FCVS application, you may contact FCVS at 1-888-ASK-FCVS. Do not call the Board's office for questions regarding the FCVS application. When all documents have been sufficiently verified, FCVS will forward your credentials package to the Board.

Enclosed is an application for licensure in the U.S. Virgin Islands.

Your interest is appreciated. If we can be of further assistance, please feel free to contact our office.

Sincerely,

Frank A. Odium, MD
Chairperson
V.I. Board of Medical Examiners
FAO/Its



REQUIREMENTS FOR MEDICAL LICENSURE IN THE U.S. VIRGIN ISLANDS

Applications for licensure shall be sent to the Virgin Islands Board of Medical Examiners, Department of Health, 1303 Hospital Ground, Suite 10, St. Thomas, Virgin Islands 00802.

The applicant shall comply with the following requirements:

1. Submit application on the form prescribed by and obtainable from the Secretary, Board of Medical Examiners.
2. Submit a recent and dated un-mounted photograph of passport size of himself/herself, autographed in ink across the back.
3. Submit a chronological account of all time spent between the date of graduation from medical school and time of application.
4. Be a graduate of an accredited school of medicine and must have satisfactorily completed at least one year internship in a hospital recognized by the American Medical Association. Copies of diploma, residency, internship & documents should be submitted with application.
5. Be twenty-one years of age or older. Copy of birth certificate or similar proof required.
6. Must have passed USMLE Steps 1, 2 & and/or Flex (as provided in Rules & Regs of the Board)
7. Be of a good moral character as shown by two **current** dated letters of character reference from members of the medical profession; one should be obtained from the Director of the applicant's hospital training program indicating the inclusive dates and type of training completed.
8. Is not addicted to intemperate use of alcoholic stimulants or narcotic drugs. A notarized Affidavit attesting to the above must be furnished.
9. If an international graduate, must possess a permanent current certificate issued by the Educational Council for Foreign Medical Graduates (ECFMG).
10. All applicants are required to have their credentials verified by the Federation of State Medical Boards Credentialing Verification Service (CVS).
11. License verification form(s) should be filled out and sent directly to **all** states for which you are licensed in. Verification form may be duplicated.
12. Authorization for release of information form should be filled out, notarized and return with application.

13. Complete self query with National Practitioner Data Bank (NPDB) by going to www.npdb-hipdb.hrsa.gov.

EXAMINATIONS:

The Board of Medical Examiners shall give written and oral examinations to all qualified applicants in accordance with the provisions of Chapter I (including all its subchapters) of Title 7, Virgin Islands Code. **There is no reciprocity with any other State.** Examinations shall be scheduled two (2) times a year, in **May** and **November**.

Applications for licensure must be submitted to the Board at least twelve (12) weeks before the date of the examination.

The candidate shall be notified by mail if they have met all requirements needed to sit for the examination. Once approved for the examination, they will have to contact the Federation of State Medical Board (FSMB) for information pertaining to the SPEX examination. This information will be given to them in their acceptance letter.

After the taking of the examination, the candidate shall be advised by the FSMB, as to their results with a copy going to V.I. Board of Medical Examiners.

MEDICAL REQUIREMENTS

A candidate who passes shall have a one (1) year limitation to take the oral examination from the time of the written notification of having passed the written component.

If a license is not activated within two (2) years of issuance, the license becomes null and void. A licensee, through a written request, can place his/her license in the inactive status.

A candidate who fails to pass both components of the examination at one sitting shall be required to retake the entire examination.

A candidate shall not be allowed any more than two re-examinations before being required to present evidence of an additional six (6) months of postgraduate training.

A candidate shall be allowed three (3) years in which to pass the two (2) allowed re-examinations.

IF ANY PORTION OF THESE REQUIREMENTS ARE NOT MET TWELVE WEEKS PRIOR TO THE EXAMINATION DATE, THE APPLICANT WILL NOT BE PERMITTED TO SIT FOR THE EXAMINATION.



GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES

- 0 -

DEPARTMENT OF HEALTH
1303 HOSPITAL GROUND, SUITE 10, ST. THOMAS, U.S. VI. 00802

VIRGIN ISLANDS
BOARD OF MEDICAL EXAMINERS

(340) 774-0117
(340) 776-8311
EXTS. 5074/5078

MEDICAL LICENSURE APPLICATION

PRINT PROFESSION/SPECIALITY

Please type or Print All Information - No Blanks

Cell _____

Home _____

E-mail Address _____

Last Name: _____ First: _____ Middle: _____

Home Address: _____ City: _____ State: _____ Zip: _____

City _____ State _____ Zip _____

Provide your primary practice mailing address

Business address: _____

City: _____ State: _____ Zip: _____

Business phone: () _____ Cell Phone: _____ Fax no. _____

Birth Date ____ / ____ / ____ Birthday Place _____

Social Security No. _____ Citizen of _____

**(If you were not born in the United States, proof of Citizenship
Must be submitted 60 days before examination.)**

Solo Practice Group practice (indicate with whom, date of affiliation) _____

DEA number _____ NPI Number _____

High School _____ Location _____

College _____ Location _____

Professional School _____ Location _____

Date Graduated ____ / ____ / ____ Degree Received _____

Time of examination requested (give month) May November

Note: Medical examination (SPEX) is taken on St. Croix

AFFIDAVIT

**PASTE PHOTOGRAPH
SECURELY IN THIS SPACE**

**Write signature on light
portion of photograph, not**

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.

State of _____)
) ss
County or City of _____)

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 crime; 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 will conform to the ethical standards of conduct in his/her profession; and that he/she has read and understands this affidavit.

*A crime would include either a felony or a misdemeanor.

(Signature of Applicant)

Date of photograph

Sworn to before me this _____ day of _____ 20_____

Notary Public

My Commission expires on _____/_____/_____

PERSONAL SIGNATURE OF PERSONS RECOMMENDING APPLICANT

This certifies that I have been personally acquainted with the applicant since the year(s) indicated opposite my name; that I believe him/her to be of a good moral character and worthy of licensure in the U.S. Virgin Islands; and that any reservations I may have about the applicant I agree to send by certified mail in a confidential letter to the Board of Medical Examiners of the U.S. Virgin Islands.

<u>Please Print Name</u>	<u>Personal Signature</u>	<u>P.O. Address (Including street & city)</u>	<u>Known Since</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Signatures are required by not fewer than three citizens unrelated to applicant who must be licensed in the profession for which an applicant wishes to be examined or who are members of the staff of the professional school.)

**Return Application to: V.I. Board of Medical Examiners
Department of Health
1303 Hospital Ground, Suite 10
St. Thomas, V I 00802**

MEDICAL LICENSE APPLICATION DATA

Medical School Attended:

Name _____

Mailing Address _____

Issuance Date of Medical Diploma _____

State(s) Licensed In:

State	_____	_____	_____	_____
Date of Issue	_____	_____	_____	_____
License Number	_____	_____	_____	_____
How Obtained	_____	_____	_____	_____
Written Exam	_____	_____	_____	_____
Oral Exam	_____	_____	_____	_____
Endorsement	_____	_____	_____	_____
Other (Explain)	_____			

USMLE: Date _____ Score _____

FLEX Date _____ Score _____

Accredited Hospital Training (Use other side if necessary)

Name of Hospital _____

Mailing Address _____

Type of Training _____ Date _____

_____ Date _____

_____ Date _____

American Medical Specialty Boards:

Specialty _____

Name and Address of Training Institution _____

Date of Training: From _____ To _____

Board Eligible: Yes _____ No _____ Date _____

Board Certified: Yes _____ No _____ Date _____

International Medical Graduates (except Canada):

Date of Certification ECFMG _____

Date of Certification VQE _____

Practice Experience:

Photocopies required of the following

Curriculum Vita
Medical Diploma
Hospital Training Documents
NBME Certificate or FLEX Scores
USMLE I, II, III Scores
Specialty Board Certificate
National Practitioner Data (NPDB) Self Query

(Please provide below preferred phone # and address for contact with this office in regards to the process of this application, if different than above)

Address: _____

City: _____ State: _____ Zip: _____

Business phone: () _____ Pager: _____ Fax no. () _____

If the answer is YES to any of the following questions, please provide details on separate sheet.

During the last year or since your previous license renewal

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? YES NO
2. Have proceedings been instituted to have your DEA or other controlled substance authorization denied, revoked or suspended? YES NO
3. Have proceedings been instituted to have your specialty board certification denied, revoked or suspended? YES NO
4. Have you voluntarily relinquished any license, certification or privileges? YES NO
5. 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. YES NO
6. Have you been reprimanded, sanctioned, censured, excluded, suspended or disqualified by Medicare, Medicaid, CLIA or any other health plan for which you provide services. YES NO
7. Have you been arrested for or charged with a crime involving children? YES NO
(If Yes, 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.)
8. Have you been convicted of a felony or are you presently indicted for a felony? YES NO

PHYSICIAN ASSISTANT/ADVANCE PRACTICE NURSE SUPERVISION

Do you supervise Physician's Assistant and/or Advance Practice Nurse in your practice? YES NO
If yes, state name(s) _____. All Physician's Assistant practicing in the V.I. **must** be licensed with the V.I. Board Medical Examiners. If your PA is not currently license in the V.I., please request an application from the Board.

SPECIALTY BOARD CERTIFICATION

SPECIALTY BOARD	CERTIFICATION DATE	EXIRATION DATE

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

CHRONOLOGICAL PROFESSIONAL HISTORY

If the answer is YES to any of the following questions, please provide full details on a separate sheet.

During the last year or since your previous license renewal

- A. 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? YES NO
- B. 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? YES NO
- YES NO
- C. 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?
- D. 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? YES NO
- E. Are there presently any proceedings or investigations taking place at any hospital or other organization relating to your clinical competence or professional conduct? YES NO
- F. 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? YES NO

Please provide all hospital affiliations, employers and locum tenens last year (since your last license renewal)

Institution: _____ From: Mo. ____ Yr. ____ To: Mo. ____ Yr. ____

Address: _____ Staff Status: _____ Phone: (____) _____

City: _____ State: _____ Zip: _____ Department: _____

Chief of Staff: _____ Department Chief: _____

Institution: _____ From: Mo. ____ Yr. ____ To: Mo. ____ Yr. ____

Address: _____ Staff Status: _____ Phone: (____) _____

City: _____ State: _____ Zip: _____ Department: _____

Chief of Staff: _____ Department Chief: _____

Institution: _____ From: Mo. ____ Yr. ____ To: Mo. ____ Yr. ____

Address: _____ Staff Status: _____ Phone: (____) _____

City: _____ State: _____ Zip: _____ Department: _____

Chief of Staff: _____ Department Chief: _____

Institution: _____ From: Mo. ____ Yr. ____ To: Mo. ____ Yr. ____

Address: _____ Staff Status: _____ Phone: (____) _____

City: _____ State: _____ Zip: _____ Department: _____

Chief of Staff: _____ Department Chief: _____

PROFESSIONAL LIABILITY HISTORY

If the answer is YES to any of the following questions, please provide full details on a separate sheet.

During the last year or since your previous license renewal:

1. 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"? YES NO

(IF YOU ANSWER "YES" PLEASE PROVIDE DETAILED INFORMATION ON THE PROFESSIONAL LIABILITY ACTION EXPLANATION ON PAGE 6.)

2. 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? YES NO

3. Have you been denied professional liability insurance or has your policy ever been canceled or denied renewal? YES NO

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.

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:: _____

Professional Liability Action Explanation Form

This form must be completed if you answered "yes" to question #1 on page 3

Please complete this form for each pending or settled professional liability action or any payment made on behalf of applicant. All questions must be answered completely. If additional sheets are required, please photocopy this page prior to completing. Please provide us with a separate sheet for each malpractice action.

Please Print

Date of Alleged Incident

Date Suit Filed

Patient Name

Location of Incident

Your Relationship to Patient (Attending Provider, Surgeon, Assistant Surgeon, Consultant, etc.)

Allegation

Liability Carrier when Incident Occurred

Additional Named Defendant(s)

Claims Status

OPEN – If open, amount being sought

CLOSED – If closed, indicate method of closing Dismissal Settlement Judgment

Amount of settlement or judgment

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. Please print.

SUMMARY

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.

In making this application for licensure, I acknowledge my obligation to provide continuous care and supervision of my patients. I acknowledge that I have received and read the **Policy for the Use of Controlled Substances for the Treatment of Pain** and agree to follow it as closely as possible if I am granted a license.

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 US 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.

_____ Date _____
Print Name

Signature

Policy for the Use of Controlled Substances for the Treatment of Pain

Section I: Preamble

The Virgin Islands Board of Medical Examiners recognizes that principles of quality medical practice dictate that the people of the Virgin Islands have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. For the purposes of this policy, the inappropriate treatment of pain includes non-treatment, under-treatment, over-treatment, and the continued use of ineffective treatments.

The diagnosis and treatment of pain is integral to the practice of medicine. The Board encourages physicians to view pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as statutory requirements for prescribing controlled substances. Accordingly, this policy has been developed to clarify the Board's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

Inappropriate pain treatment may result from physicians' lack of knowledge about pain management. Fears of investigation or sanction by federal, state and local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. As such, the Board will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

The Board recognizes that controlled substances including opioid analgesics may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The Board will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain. The medical management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and non-pharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.

The Virgin Islands Board of Medical Examiners is obligated under the laws of the United States Virgin Islands to protect the public health and safety. The Board recognizes that the use of opioid analgesics for other than legitimate medical purposes pose a threat to the individual and society and that the inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the Board expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

Physicians should not fear disciplinary action from the Board for ordering, prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the course of professional practice.

The Board will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

The Board will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors.

Allegations of inappropriate pain management will be evaluated on an individual basis. The board will not take disciplinary action against a physician for deviating from this policy when contemporaneous medical records document reasonable cause for deviation. The physician's conduct will be evaluated to a great extent by the outcome of pain treatment, recognizing that some types of pain cannot be completely relieved, and by taking into account whether the drug used is appropriate for the diagnosis, as well as improvement in patient functioning and/or quality of life.

Section II: Guidelines

The Board has adopted the following criteria when evaluating the physician's treatment of pain, including the use of controlled substances:

Evaluation of the Patient - A medical history and physical examination must be obtained, evaluated, and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

Treatment Plan - The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

Informed Consent and Agreement for Treatment - The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse, the physician should consider the use of a written agreement between physician and patient outlining patient responsibilities, including

- urine/serum medication levels screening when requested;
- number and frequency of all prescription refills; and
- reasons for which drug therapy may be discontinued (e.g., violation of agreement).

Periodic Review - The physician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the

physician's evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

Consultation - The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

Medical Records - The physician should keep accurate and complete records to include

1. the medical history and physical examination,
2. diagnostic, therapeutic and laboratory results,
3. evaluations and consultations,
4. treatment objectives,
5. discussion of risks and benefits,
6. informed consent,
7. treatments,
8. medications (including date, type, dosage and quantity prescribed),
9. instructions and agreements and
10. periodic reviews.

Records should remain current and be maintained in an accessible manner and readily available for review.

Compliance With Controlled Substances Laws and Regulations—To prescribe, dispense or administer controlled substances, the physician must be licensed in the US Virgin Islands and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration for specific rules governing controlled substances as well as applicable state regulations.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute Pain - Acute pain is the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. It is generally time-limited.

Addiction - Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

Chronic Pain - Chronic pain is a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.

Pain - An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical Dependence - Physical dependence is a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

Pseudoaddiction - The iatrogenic syndrome resulting from the misinterpretation of relief seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief seeking behaviors resolve upon institution of effective analgesic therapy.

Substance Abuse - Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance - Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.



VERIFICATION OF LICENSURE

APPLICANT IS REQUIRED TO COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE MEDICINE AND SURGERY OR OSTEOPATHIC MEDICINE AND SURGERY. IF NEEDED, YOU MAY XEROX THIS FORM FOR ADDITIONAL COPIES.

To Whom It May Concern:

I am being considered for medical licensure in the Territory of the U.S. Virgin Islands. The V.I. Board of Medical Examiners requires that this form be completed by each state in which I am now or have ever been licensed to practice my profession. Enclosed is my authorization for release of information. **Please forward this form directly to: VI Board of Medical Examiners, Department of Health, 1303 Hospital Ground, Suite 10, St. Thomas, VI 00802.**

Applicant's Signature

Name: _____

Address: _____

My License No. in your State: _____

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: _____

Date: _____

BOARD SEAL



AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Virgin Islands Board of Medical Examiners 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.

Signature

Date

Print Name

Subscribed and sworn to before me this ____ day of _____ 20__

Notary Public

My Commission Expires