



Government of  
The Virgin Islands of the United States  
-0-  
Department of Health  
48 Sugar Estate, St. Thomas, U.S. VI. 00802

Virgin Islands  
Board of Medical Examiners

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

Dear \_\_\_\_\_:

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 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 fee in the amount of \$250.00, made payable to Government of the V.I.
4. Submit chronological account of all time spent between receiving your P.A. certification and/or degree prior to this application.
5. Proof of completing an accredited education program (copy of certificate required).
6. Be twenty-one years of age or older (copy of birth paper and/or similar proof).
7. Is not addicted to intemperate use of alcoholic stimulants or narcotic drugs. A notarized Affidavit attesting to this must be furnished.
8. Two character reference letters by someone who knows of you and/or worked with you.
9. Submit any other information the board deems necessary to evaluate your qualifications.
10. All applicants are required to have their credentials verified by the Federation of State Medical Boards Credentialing Verification Service - [www.fsmb.org/fcvs\\_paapp.html](http://www.fsmb.org/fcvs_paapp.html)

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

Sincerely,

*Frank O. Odum, MD*

Frank O. Odum, MD, Secretary  
V.I. Board of Medical Examiners



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

APPLICATION FOR PHYSICIAN ASSISTANT IN THE U.S. VIRGIN ISLANDS

PRINT PROFESSION

Please Fill Out and Return Immediately

E-Mail
Print Name
Address
City
Home Address
Birth Date
Social Security No.

Citizen of (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
College
Professional School
Date Graduated
If employed, give name and address of employer

Has any State rejected your application or revoked your professional license?
Have you ever been convicted of any crime or unprofessional conduct?

\*Complete the attached License Application Data Form.

\*\* New Address

Do Not Write Below Fee Stamp
App. Of Qualifications
PRE. BY
DATE
PROF. BY
EXP. BY
DATE
Approval of License
BY
DATE
BY
LIC. NO.
TO CAND.
\*\*ADDRESS





**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 \_\_\_\_\_

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Name of Institution and/or Supervising Physician \_\_\_\_\_

Mailing Address \_\_\_\_\_

\_\_\_\_\_

Type of Practice \_\_\_\_\_ Dates \_\_\_\_\_

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Name of Institution and/or Supervising Physician \_\_\_\_\_

Mailing Address \_\_\_\_\_

\_\_\_\_\_

Type of Practice \_\_\_\_\_ Dates \_\_\_\_\_



**VERIFICATION OF LICENSURE**

**APPLICANT IS REQUIRED TO COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH HE/SHE ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE AS A PHYSICIAN ASSISTANT. IF NEEDED, YOU MAY XEROX THIS FORM FOR ADDITIONAL COPIES.**

To Whom It May Concern:

I am being considered for physician assistant 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, #48 Sugar Estate, St. Thomas, VI 00802.**

\_\_\_\_\_  
Applicant's Signature

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

My License No. in Your State: \_\_\_\_\_

**-----  
THIS SECTION IS 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: \_\_\_\_\_

Is license current and in good standing? \_\_\_\_\_ If NO, furnish details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has any disciplinary action ever been taken against the above named physician assistant? \_\_\_\_\_ If YES, furnish details.  
\_\_\_\_\_  
\_\_\_\_\_

Comments, if any:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BOARD SEAL**

Signed: \_\_\_\_\_

Title: \_\_\_\_\_

State Board: \_\_\_\_\_

Date: \_\_\_\_\_



## 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

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

#### **Instructions for completion 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 taken into account 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 the additional duties, if any, as listed in Form A, unless the alternate physician has completed Form A.

**Form C:**

In order 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 chart review, to insure compliance with the 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 service(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)

(etc)

(etc)

# 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)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_