

**STATE OF UTAH
DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING**

APPLICATION FOR LICENSURE

**RETIRED VOLUNTEER HEALTH CARE
PRACTITIONER**

APPLICATION INSTRUCTIONS AND INFORMATION

General Statement: The Utah Division of Occupational and Professional Licensing (DOPL) desires to provide courteous and timely service to all applicants for licensure. To facilitate the application process, **submit a complete application form including all applicable supporting documents.** Failure to submit a complete application and supply all necessary information will delay processing and may result in denial of licensure. The fees are for processing your application and will not be refunded. **Please read all instructions carefully.**

Address of Record: The address you provide on this application will be your address of record. All correspondence from DOPL will be sent to that address. You are responsible to directly notify DOPL of any change to your address of record. Do not rely on a forwarding order.

Social Security Number: Your social security number is classified as a private record under the Utah Government Records Access and Management Act. It is used by DOPL as an individual identifier. It is also used for child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements 42 U.S.C. 666(a)(13). If an SSN is not provided, the application is incomplete and may be denied.

SUPPORTING DOCUMENTS:

In addition to submitting a completed application, complete the following:

1. Submit official transcript with degree and graduation date posted for the profession you were previously licensed in and for which you want to volunteer.
2. Submit official verification of examinations you took and passed for the profession you were previously licensed and for which you want to volunteer.
3. Submit **official** verification of having been previously issued an unrestricted license to practice in another state of the United States. Request that the verifying state complete the form and mail it directly to DOPL. (*page 19 & 20 of this application*)
4. Submit a completed take-home “Utah Controlled Substances Law and Rules Examination” (*page 17 and 18 of this application*). Only applicable if permitted under the profession and required for the volunteer position.

ADDITIONAL IMPORTANT INFORMATION:

1. **FEES:** There are no fees for the Retired Volunteer Health Care Practitioner or the Controlled Substance Licenses. There is a fee for the DEA registration. *(See # 5 below)*
2. **Controlled Substances Law and Rules Examination:** Enclosed with this application is the take-home Utah Controlled Substances Law and Rules Examination. Return the completed examination with your application for licensure. Do not submit it separately. All applicable laws and rules are available on the Internet at www.dopl.utah.gov.
3. **Current Documents:** Applications, statutes, rules, and forms are occasionally changed. Go to www.dopl.utah.gov to ensure you have the most recent version of these documents.
4. **Controlled Substance License:** You must hold a Utah controlled substance license **AND** a federal DEA registration to administer, possess or prescribe a controlled substance in your practice in Utah.
5. **DEA Registration:** For DEA registration information, contact the Drug Enforcement Administration, Salt Lake District Office, 348 East South Temple, Salt Lake City, UT 84088. Telephone (801) 524-4389.

6. **License Renewal:** All volunteer license renewals coincide with the renewal for the primary profession that you are volunteering for and must be renewed at that time.

If you possess a controlled substance license, it will expire at the same time as your retired volunteer health professional license and will also need to be renewed.

Unlike many other states, Utah’s license renewal schedule **is not** based on the licensee’s date of initial licensure. Under Utah’s renewal system, all licenses in each profession expire as a group on the same day every two years. Therefore, the length of a licensee’s first renewal cycle depends on how far into the current renewal cycle initial licensure was obtained. Each renewal cycle thereafter is for a full two years.

Each licensee is responsible to renew licensure. **This license is not eligible for inactive status.**

7. **Submit Completed Application to:**

By U.S. Mail	Division of Occupational & Professional Licensing P.O. Box 146741 Salt Lake City UT 84114-6741
By Express Mail or In Person	Division of Occupational & Professional Licensing 1 st Floor Lobby 160 E 300 S Salt Lake City UT 84111-2305

8. **Telephone Numbers:** (801) 530-6628
(866) 275-3675 – Toll-free in Utah
9. **Fax Number:** (801) 530-6511

APPLICATION FOR LICENSURE

RETIRED VOLUNTEER HEALTH CARE PRACTITIONER

CONTROLLED SUBSTANCE *(For Qualified Retired Volunteer Health Care Practitioners)*

Please list your <u>full legal name</u> as it appears on your driver's license, Social Security Card, etc.				
Last Name:		First Name:		Middle Name:
Social Security Number: - -			Maiden Name:	
I certify under penalty of perjury that:				
<input type="checkbox"/> I am a citizen of the United States and I have a valid US Driver License or US State ID. License/State ID Number: _____ State: ____				
<input type="checkbox"/> I am a citizen of the United States currently living outside the United States and do not have a valid US Drivers License or US State ID. Please attach a legible copy of your valid passport or other documentation to verify you are a legal citizen of the United States.				
<input type="checkbox"/> I am a non-citizen of the United States, who is lawfully present in the United States and I have a valid US Drivers License or US State ID. License/State ID Number: _____ State: ____				
<input type="checkbox"/> I am a non-citizen of the United States, who is lawfully present in the United States and I do not have a valid US Drivers License or US State ID. Please attach a legible copy of your current and valid government issued document showing evidence of authorization to work in the United States.				
<input type="checkbox"/> I am a foreign national not physically present in the United States.				
Mailing Address:				
City:			State:	ZIP:
<input type="checkbox"/> Male	Date of Birth:	Phone #:	E-Mail:	
<input type="checkbox"/> Female				
List all other licenses, registrations, or certifications issued by any state which you now hold or have ever held in any profession. <i>(Use additional sheets if necessary.)</i>				
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	

<i>DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY</i>	
License/Certificate Number: _____	
Date License/Certificate Approved: ____/____/____	
Approved By: _____	
Date License/Certificate Denied: ____/____/____	
Denied By: _____	
Reason for Denial/Other Comments: _____	

AFFIDAVIT and RELEASE AUTHORIZATION

1. I certify that I am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, forgery, misrepresentation, omission of material fact; is truthful, correct, and complete; discloses all material facts regarding the applicant; and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I certify under penalty of perjury I hereby certify to the Division and the Board that I will engage exclusively in volunteer health care services only.
6. I certify under penalty of perjury I hereby certify to the Division and the Board that I will not receive remuneration or compensation as defined in Section 58-13-3.

Signature of Applicant: _____ Date of Signature: ___ / ___ / _____

AFFIDAVIT FOR DELEGATION OF SERVICES AGREEMENT:

I declare under penalty of perjury as follows:

I have completed a "Delegation of Services Agreement" with my supervisor. I have provided a copy of the agreement to the Division and the original is on file at the Charity practice site.

The agreement defines the working relationship, and delegation of duties between me and my supervisor and includes all of the following:

How the supervisor will be reached during the time the volunteer is providing volunteer services and supervision schedule with the Supervising Professional for every 40 hours of volunteer service hours.

Signature of the Volunteer: _____ Date of Signature: ___ / ___ / _____

Signature of Supervisor: _____ Date of Signature: ___ / ___ / _____

VOLUNTEER HEALTH CARE PRACTITIONER

ADJUNCTIVE

- Occupational Therapist
- Occupational Therapist Assistant
- Physical Therapist

DENTAL

- Dentist
- Dental Hygienist

MEDICAL

- Physician/Surgeon
- Osteopathic Physician/Surgeon
- Podiatric Physician
- Optometrist
- Physician Assistant

MENTAL HEALTH

- Psychologist
- Marriage & Family Therapist
- Professional Counselor

NURSING

- Advanced Practice Registered Nurse
- APRN-CRNA
- Certified Nurse Midwife
- Licensed Practical Nurse
- Register Nurse

PHARMACY

- Pharmacist

RECREATIONAL THERAPIST

- Master Therapeutic Recreational Specialist
- Therapeutic Recreational Specialist
- Therapeutic Recreational Technician

SOCIAL WORK

- Licensed Clinical Social Worker
- Certified Social Worker
- Social Service Worker

REQUEST FOR APPROVAL OF QUALIFIED LOCATIONS

Complete the following for each of your practice sites. (Use additional sheets if necessary.)

Charity Information:

Name of Charity Care Organization/Facility:

Type of Organization: Church Clinic Hospital

Other, please identify _____

Charity Address: _____

Charity City: _____ State: _____ Zip: _____

Charity Telephone: _____

Population Served: _____

Mission of Organization: _____

Amount of hours volunteering: _____ per week or per month

Percent of supervision for every 40 hours of volunteer hours: _____

Does your profession require supervision for your services: Yes or No

Means of communication with supervisor during the time of providing volunteer services:

Telephone Pager On Site Other, please list _____

Designation of Supervising Professional:

As listed on the Delegation of Service Agreement:

Supervisor's Name: _____

Supervisor's Active Utah License Type: _____

Supervisor's Active Utah License Number: _____

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VOLUNTEER HEALTH CARE PRACTITIONER DELEGATION OF SERVICES AGREEMENT

A Delegation of Services Agreement is to be maintained at each practice site and is to be on file with DOPL. It consists of written criteria jointly developed by a supervisor and the volunteer professional that permits a volunteer professional, to assist charity locations within the scope of the primary practice of the volunteer professional's practice act.

The following information must be legible. *(Use additional sheets if necessary.)*

SUBMIT A COPY OF YOUR DELEGATION OF SERVICES AGREEMENTS TO DOPL WITH YOUR APPLICATION FOR LICENSURE.

Volunteer Professional Name: _____

Supervisor's Name: _____

Supervisor's Utah License Number: _____

PRACTICE SITE(S):

1. Name of Charity Care Organization/Facility:

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

2. Name of Charity Care Organization/Facility:

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

(Continued on the next page.)

DEGREE AND MEANS OF SUPERVISION:

The supervising professional shall provide supervision to the volunteer to adequately serve the health care needs of the practice population and ensure that the patient’s health, safety, and welfare will not be adversely compromised.

If the volunteer’s professional practice act requires supervision,
List the process by which this supervision will be accomplished:

List the method of immediate consultation whenever the volunteer is not under the direct supervision of the supervising professional:

List the process and degree of onsite supervision:

FREQUENCY AND MECHANISM OF CHART REVIEW:

List the method for chart review and co-signatures of the supervising professional for supervision. Include the process for chart review and co-signatures required by the professional practice act:

(Continued on the next page.)

PRESCRIBING OF CONTROLLED SUBSTANCES:

A volunteer may prescribe or administer an appropriate controlled substance if the volunteer holds a current Utah controlled substance license covering the appropriate schedules of controlled substances and a current DEA registration covering the appropriate schedules of controlled substances; the prescription or administration of the controlled substance is within the prescriptive practice of the supervising professional and also within the delegated prescribing stated in the delegation of services agreement; and the supervising professional co-signs any medical chart record of a prescription of a Schedule 2 or Schedule 3 controlled substance made by the volunteer.

In order to prescribe controlled substances, the volunteer must have obtained his or her own controlled substance license and DEA registration. The volunteer may not use his or her supervising professional’s controlled substance licenses or DEA registrations.

Please define the process for the volunteer prescribing controlled substances and expectations.

SCOPE OF PRACTICE:

Please define procedures addressing how situations outside the volunteer’s scope of practice will be handled.

(Continued on the next page.)

EMERGENCY SITUATIONS:

List procedures for providing backup support for the volunteer in emergency situations:

ADDITIONAL CONSIDERATIONS RELATING TO OUR PRACTICE:

List any additional items, procedures, and expectations pertinent to the volunteer’s practice at the charity site:

Signature of Volunteer: _____

Date of Signature: ____/____/____

Signature of Supervising Professional: _____

Date of Signature: ____/____/____

NOTE: A copy of this “Delegation of Services Agreement” is required to be available at the charity practice site(s) and on file with DOPL. The agreement needs to accurately reflect current practices.

QUALIFYING QUESTIONNAIRE

Answer “yes” or “no” for each question. Do not leave any question blank.

1. _____ Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
2. _____ Have you ever been denied the right to sit for a licensure examination?
3. _____ Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
4. _____ Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care professional licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
5. _____ Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency or governmental agency?
6. _____ Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
7. _____ Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
8. _____ Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?
9. _____ Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
10. _____ Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?
11. _____ Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?

(Continued on the next page.)

12. _____ Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?
13. _____ Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
14. _____ Is any action pending against you now by either the Federal Drug Enforcement Administration or any state drug enforcement agency?
15. _____ Have you been named as a defendant in a malpractice suit?
16. _____ Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions, or conditions imposed by any malpractice carrier?
17. _____ Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
18. _____ If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
19. _____ Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
20. _____ Have you been terminated from a position because of drug use or abuse within the past five (5) years?
21. _____ Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
22. _____ Are you currently using or have you recently (*within 90 days*) used any drugs (*including recreational drugs*) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?
23. _____ Have you ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law, for which you have not successfully completed or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?

(Continued on the next page.)

24. _____ Do you currently have any criminal action pending?
25. _____ Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.
26. _____ Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
27. _____ Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed (*i.e. plea in abeyance or deferred sentence*)?
28. _____ Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?



If you answered "yes" to question 15 above, you must submit a National Professional Database document outlining all professional liability claims made against your license and any settlements paid by or on your behalf.

Additionally, if you answered "yes" to questions 23, 24, 25, 26, 27, or 28 above, you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.



If you answered "yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

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**UTAH CONTROLLED SUBSTANCES
LAW AND RULES EXAMINATION**

This examination is not intended to be difficult. The purpose of the exam is to bring to your attention specific practice issues you need to know in order to avoid violating Utah statute as well as Utah law and rule. If you are uncertain about any of the questions listed below, please refer to the references listed in order to become familiar with Utah’s controlled substance prescribing practices.

Utah Controlled Substances Act, 58-37 <http://dopl.utah.gov/laws/58-37.pdf>

Utah Controlled Substances Act Rule, R156-37 <http://dopl.utah.gov/laws/R156-37.pdf>

Answer “**True**” or “**False**” for each statement. Submit this completed examination with your application for licensure.

<input type="checkbox"/> True <input type="checkbox"/> False	1. A prescription for a schedule II controlled substance may be filled in a quantity not to exceed a 30 day supply.
<input type="checkbox"/> True <input type="checkbox"/> False	2. A prescription for a schedule III or IV controlled substance may be refilled 5 times within a six month period from the issue date of the prescription.
<input type="checkbox"/> True <input type="checkbox"/> False	3. All prescription orders must be signed in ink or indelible pencil to prevent anyone from altering a legitimate prescription.
<input type="checkbox"/> True <input type="checkbox"/> False	4. Licensed prescribing practitioners must make their controlled substance stock and records available to DOPL personnel for inspection during regular business hours.
<input type="checkbox"/> True <input type="checkbox"/> False	5. All records of purchasing, prescribing, and administering controlled substances must be maintained by the licensed prescribing practitioner for at least five years.
<input type="checkbox"/> True <input type="checkbox"/> False	6. The name, address, and DEA registration number of the prescribing practitioner, and the name, address and age of the patient are required to be included on the prescription for a controlled substance.
<input type="checkbox"/> True <input type="checkbox"/> False	7. A controlled substance is taken according to the prescriber’s instructions. A refill may be dispensed after 80% of the medication has been consumed.
<input type="checkbox"/> True <input type="checkbox"/> False	8. After the discovery of any theft or loss of a controlled substance, the prescribing practitioner is required to file the appropriate forms with the DEA, report the incidence to the local police, and send copies of the filed DEA forms to DOPL.
<input type="checkbox"/> True <input type="checkbox"/> False	9. The maximum number of controlled substances that can be written on a single prescription form is one.
<input type="checkbox"/> True <input type="checkbox"/> False	10. An emergency verbal prescription order for a schedule II controlled substance requires that the patient be under the continuing care of the prescribing practitioner for a chronic disease, the amount of drug prescribed is limited to what is needed to adequately treat the patient for no more than 72 hours, and a written prescription shall be delivered to the filling pharmacy within 7 working days of the verbal order.
<input type="checkbox"/> True <input type="checkbox"/> False	11. Issuing a prescription for a schedule II or III controlled substance for yourself is considered unprofessional conduct and may result in disciplinary action.
<input type="checkbox"/> True <input type="checkbox"/> False	12. A prescribing practitioner is using a schedule IV controlled substance in the treatment of weight reduction for obesity. The practitioner has completed a medical history of the patient, has performed a complete physical examination, has ruled out contra-indications, and has determined that the health benefits of treatment greatly out-weigh the risks. An informed consent signed by the patient is also required prior to initiating treatment.
<input type="checkbox"/> True <input type="checkbox"/> False	13. The Division will immediately suspend the Utah controlled substance license if the DEA registration is denied, revoked, surrendered, or suspended.

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Utah Division of Occupational and Professional Licensing
160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741

REQUEST FOR VERIFICATION OF LICENSE

(Use this form to verify licensure from another state, if applicable.)

PART 1 – TO BE COMPLETED BY THE APPLICANT:

Complete the first section of the form and submit it to a state in which you are **currently** licensed as a practitioner. Request that the verifying state complete the form and mail it directly to DOPL or return it to you for submission with your application.

Applicant Name: _____

Street Address: _____

City: _____

State: _____ Zip: _____

I am requesting licensure in the state of Utah as a _____

I am/have been licensed in your state under the name _____

My social security number is _____

My date of birth is ___/___/___

My license number in your state is/was _____

I have enclosed the necessary license verification fee in the amount of \$ _____

Signature of Applicant: _____

Date of Signature: ___/___/___

(Continued on the next page.)

PART 2 – TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested, sign and verify the document, and mail it directly to DOPL or place the completed form in a sealed envelope and provide it to the applicant in person or by mail. The applicant will include the sealed verification of licensure with his/her Utah application.

Thank you.

Name of Verifying State: _____

Name of Licensee (*as it appears in verifying state's records*): _____

Classification of License Issued: _____

License Number: _____ Current Status: _____

Original Date of Licensure: ___/___/___ Expiration Date: ___/___/___

Continuously Licensed:

Yes No, please explain: _____

Licensed By:

Exam, Type: _____ Date: ___/___/___

Endorsement: from what state? _____

Examination Scores: _____

Education Required for Licensure: _____

Disciplinary Action or Pending Disciplinary Action:

No Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: _____

Title: _____

Agency: _____

Date of Signature: ___/___/___

(SEAL)