State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

Retired Volunteer Health Care Practitioner

APPLICANT INFORMATION

Full Legal Name: _____
First *Middle* *Last*

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

_____
City *State* *ZIP Code*

Phone: _____ **Email:** _____

Please Select ONE:

- ☐ I am a United States citizen OR a non-citizen of the United States who is lawfully present.
- ☐ I am a foreign national not physically present in the United States.
- ☐ None of the above, please explain: _____

Driver License or State ID Card: _____
State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of authorization to work in the United States.

AFFIDAVIT AND RELEASE

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 all supporting document(s) are true and correct, 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, organizations, governmental agencies, or any others not specifically listed, 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 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 that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.
6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Applicant: _____ Date: _____

QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer each question. Do not leave any question blank.

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.

1. ☐ Yes ☐ No	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?
2. ☐ Yes ☐ No	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 professional licensing agency or criminal or administrative jurisdiction?
3. ☐ Yes ☐ No	Are you currently under investigation or is any disciplinary action pending against you now by any *local, state or federal licensing, enforcement or regulatory agency?*
4. ☐ Yes ☐ No	Have you ever been declared by any court to be incompetent by reason of mental defect or disease and not restored?
5. ☐ Yes ☐ No	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?
6. ☐ Yes ☐ No	Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug or alcohol use or abuse within the past five (5) years?
7. ☐ Yes ☐ No	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 applicable state or federal laws?
8. ☐ Yes ☐ No	Have you ever unlawfully used any drugs 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?
9. ☐ Yes ☐ No	Do you currently have any criminal action pending?*****
10. ☐ Yes ☐ No	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? *****
11. ☐ Yes ☐ No	Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?*****
12. ☐ Yes ☐ No	Have you ever been incarcerated for any reason in any correctional facility (*domestic or foreign*) in any jurisdiction or on probation/parole in any jurisdiction?*****

***NOTE:* Charges that were later dismissed and motor vehicle offenses such as driving while impaired or intoxicated must be disclosed; however, minor traffic offenses such as parking or speeding violations need not be listed.**

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.

If you answered **"Yes"** to Questions **9,10,11** or **12** you must submit the following for **EACH** and **EVERY** incident:

- Personal account of the incident(s)
- police report(s)
- court record(s)
- 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.

PROFESSIONAL LICENSES

List all other licenses, registrations or certifications issued by any state which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

PROFESSION

Only Health Care Practitioners identified in 58-81-102 are eligible for Retired Volunteer Health Care Practitioner Licensure. Please select one of the professions below:

Adjunctive
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Master Therapeutic Recreational Specialist
- ☐ Therapeutic Recreational Specialist
- ☐ Therapeutic Recreational Technician

Medical
- ☐ Physician/Surgeon*
- ☐ Osteopathic Physician/Surgeon*
- ☐ Podiatric Physician*
- ☐ Optometrist*
- ☐ Physician Assistant*

Nursing
- ☐ Advanced Practice Registered Nurse*
- ☐ APRN-CRNA*
- ☐ Certified Nurse Midwife*
- ☐ Licensed Practical Nurse
- ☐ Registered Nurse

Dental
- ☐ Dentist *
- ☐ Dental Hygienist

Mental Health
- ☐ Marriage and Family Therapist
- ☐ Clinical Mental Health Counselor
- ☐ Licensed Clinical Social Worker
- ☐ Certified Social Worker
- ☐ Social Service Worker
- ☐ Psychologist

Pharmacy
- ☐ Pharmacist*

**Professions that qualify for an optional Controlled Substance License. If applying for CS licensure, please complete the "Utah Controlled Substance Affidavit" on the next page.*

I understand that, once issued, a Retired Volunteer Health Care Practitioner License is valid only for volunteer service at the qualified location and I cannot receive any compensation for services provided. I further understand that I must practice within the confines of a delegation of service agreement and under the supervision of an approved professional. Any changes to the delegation of service or approved supervisor must be reported immediately to the Division.

Signature of Applicant:_____ Date _____

LICENSE QUALIFICATIONS

Please complete the following documenting the education and exam requirements met to obtain your original license.

Qualifying Education:

Name of School: _____ Location: _____

Date Enrolled: _____ Date of Graduation/Completion: _____ Degree Received: _____

Post Graduate Education or Training (if applicable):

Name of Facility: _____ Location: _____

Date Began: _____ Date of Ended: _____ Position: _____

Name of Facility: _____ Location: _____

Date Began: _____ Date of Ended: _____ Position: _____

Professional Exam(s):

Exam Type	Date(s) Taken	Score(s)

MEDICAL QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer each question. Do not leave any question blank.

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.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

3. Is any action pending against you now by:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

4. ☐ Yes ☐ No Have you been named as a defendant in a malpractice suit?

5. ☐ Yes ☐ No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered **"Yes"** to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: http://www/npdb.hrsa.gov.*

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.

UTAH CONTROLLED SUBSTANCE AFFIDAVIT (OPTIONAL)

If you are applying for a controlled substance license, you must read and sign the affidavit below.

1. I have reviewed and understand that I must abide by the additional laws and rules that govern the practice of my profession as it pertains to controlled substances.

2. I understand that I may need a written delegation of services agreement or a written consultation and referral plan for prescribing controlled substances as outlined in statute.

3. I understand that there may be additional continuing education requirements for those who hold a controlled substance license.

4. I understand it is required that I hold a valid Federal Drug Enforcement Administration (DEA) registration.

Signature of Applicant:_____ Date _____

Note: *In addition to signing this affidavit, you must complete the items listed on the OPTIONAL CONTROLLED SUBSTANCE LICENSE checklist at the end of this application.*

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.

APPLICANT INFORMATION

Full Legal Name: _____
First *Middle* *Last*

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

_____
City *State* *ZIP Code*

Phone: _____ **Email:** _____

SUPERVISOR INFORMATION

Name of Qualified Location: _____

Supervisor: _____ **License Number:** _____

Substitute Supervisor: _____ **License Number:** _____

Establishment Address: _____
Street/PO Box *City* *State/Zip*

Telephone Number _____ **Email:** _____

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.

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. Include the process for chart review and co-signatures required by the professional practice act:

PRESCRIBING OF CONTROLLED SUBSTANCES

A volunteer practitioner 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.

In order to prescribe controlled substances, the volunteer practitioner must have obtained his or her own controlled substance license and DEA registration. The volunteer practitioner may not use his or her supervising professional's controlled substance licenses or DEA registrations. The volunteer practitioner may not prescribe a controlled substance to himself, the volunteers family or a staff member.

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

SCOPE OF PRACTICE

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

EMERGENCY SITUATIONS

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

ADDITIONAL CONSIDERATIONS

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

Signature of Volunteer: _____ **Date:** _____

Signature of Supervisor: _____ **Date:** _____

Signature of Substitute Supervisor: _____ **Date:** _____

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.

APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience, you do not need to include it with your application.
NOTE: Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

The following items are required to complete your application:

- Supporting documentation for any "yes" answers provided on either of the questionnaires.
- Complete and current curriculum vitae or resume outlining your professional work history.
- Copy of Delegation of Services Agreement for each practice location. The original must be kept at each practice site and be available upon request.

If you have never held a Utah license in the same profession selected on page 3 of this application, you must submit:

- Official verification of license from at least one state in which you have held an unrestricted license for the profession selected. If possible, the verification should include verification of education, degrees and exams. **Note: If the state you are requesting licensure from cannot supply supporting documentation of the requirements met, please contact the board directly for additional instructions.*

NOTE: Once issued, the controlled substance license (if applicable) will be connected to your primary license, and will expire at the same time. You must contact the DEA separately to obtain your DEA number. Additional renewal requirements may apply.

Submit the above items with your completed application to:

In person or via express delivery:
Division of Occupational and Professional Licensing
Heber M Wells Building, 1st Floor Lobby
160 E 300 S
Salt Lake City, UT 84111

US Postal Service:
Division of Occupational and Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741