

**FINAL REGULATIONS**

**18 VAC 85-20-10 et seq.**

***Regulations Governing the Practice of Medicine, Osteopathy, Podiatry, Chiropractic and Physician  
Acupuncture***

**Part VII.**

**Practitioner Profile System.**

**18 VAC 85-20-280. Required information.**

A. In compliance with requirements of § 54.1-2910.1 of the Code of Virginia, a doctor of medicine or osteopathy [or a doctor of podiatry] licensed by the board shall provide, upon initial request, the following information within 30 days:

1. The address of the primary practice setting and all secondary practice settings with the percentage of time spent at each location;
2. Names of medical [, or] osteopathic [or podiatry schools] and graduate medical [or podiatric] education programs attended with dates of graduation or completion of training;
3. Names and dates of specialty board certification, if any, as approved by the American Board of Medical Specialties [, or] the American Board of Osteopathic Medical Specialties [, or the American Board of Podiatric Surgery];
4. Number of years in active, clinical practice in the United States or Canada, following

completion of medical [or podiatric] training and the number of years, if any, in active, clinical practice outside the United States or Canada;

5. The specialty[,if any] in which the physician [or podiatrist] practices;

6. Names of insurance plans accepted or managed care plans in which the physician [or podiatrist] participates [and whether he is accepting new patients under such plans];

7. Names of hospitals with which the physician [or podiatrist] is affiliated;

8. Appointments within the past ten years to medical [or podiatry] school faculties with the years of service and academic rank;

9. Publications, not to exceed ten in number, in peer-reviewed literature within the most recent five-year period.

10. Whether there is access to translating services for non-English speaking patients at the primary practice setting, and which, if any, foreign languages are spoken in the practice;

11. Whether the physician [or podiatrist] participates in the Virginia Medicaid Program participates [and whether he is accepting new Medicaid patients];

B. The physician [or podiatrist] may provide additional information on hours of continuing education earned, subspecialities obtained, honors or awards received.

C. [~~After the initial request for information, the licensee shall provide to the board, within 30 days, current information in any of the above categories~~ Whenever there is a change in the information on record with the practitioner profile system], the practitioner shall provide current information in any of the above categories within 30 days of such change].

**18 VAC 85-20-290. Reporting of malpractice paid claims [and board actions].**

[A.] All malpractice paid claims reported to the Board of Medicine within the ten years immediately preceding the report shall be used to calculate the level of significance as required by §54.1-2910.1 of Code of Virginia. Each report of an award or settlement shall indicate:

1. The number of years the physician [or podiatrist] has been licensed in Virginia.
2. The specialty in which the physician [or podiatrist] practices.
3. The relative frequency of paid claims described in terms of the number of physicians [or podiatrists] in each specialty and the percentage who have had made malpractice payments within the ten-year period.
4. The date of the paid claim.

5. The relative amount of the paid claim described as average, below average or above

average, which shall be defined as follows:

a. “Average” if the amount of the award is within one standard deviation above or below the mean for the amount of all reported claims for physicians [or podiatrists] who share the same specialty as the subject of the report;

b. “Below average” if the amount of the award is below one standard deviation from the mean for the amount of all reported claims for physicians [or podiatrists] who share the same specialty as the subject of the report; and

c. “Above average” if the amount of the award is above one standard deviation from the mean for the amount of all reported claims for physicians [or podiatrists] who share the same specialty as the subject of the report.

[B. The board shall make available as part of the profile information regarding disciplinary notices and orders as provided in § 54.1-2400.2 D of the Code of Virginia.]

**18 VAC 85-20-300. Non-compliance or falsification of profile.**

A. The failure to provide the information required by subsection A of 18 VAC 85-20-280 within 30 days of the request for information by the board may constitute unprofessional conduct and may subject the licensee to disciplinary action by the board.

B. Intentionally providing false information to the board for the practitioner profile system shall constitute unprofessional conduct and shall subject the licensee to disciplinary action by the board.

## **Listing of Forms**

### **18 VAC 85-20-10 et seq.**

### **Regulations Governing the Practice of Medicine, Osteopathy, Podiatry, Chiropractic, and Physician Acupuncture**

#### **Regulations of the Board of Medicine**

Instructions for Completing FLEX or USMLE Endorsement Application; American Graduates - revised May, 1997.

Instructions for Completing FLEX or USMLE Endorsement Application; Non-American Graduates - revised June, 1997.

Instructions for Completing PMLEXIS Examination Application - revised May, 1997.

Instructions for Completing Chiropractic Endorsement Application - revised May, 1997.

Instructions for Completing Podiatry Endorsement Application - revised May, 1997.

Instructions for Completing LMCC Endorsement Application; Canadian/American Graduates - revised May, 1997.

Instructions for Completing LMCC Endorsement Application; Non-American Graduates - revised June, 1997.

Instructions for Completing National Boards Endorsement Application - revised May, 1997.

Instructions for Completing Osteopathic National Boards Endorsement Application - revised May, 1997.

Instructions for Completing Other Boards Endorsement Application; American Graduates - revised May, 1997.

Instructions for completing Other Boards endorsement application; Non-American graduate - revised June, 1997.

Form #A, Claims History Sheet - revised June, 1997.

Form #B, Activity Questionnaire - revised June, 1997.

Form #C, Clearance from Other State Boards - revised June, 1997.

Form #D, Virginia Request for Physician Profile - revised June, 1997.

Application for a License to Practice Medicine/Osteopathy - revised May, 1997.

Form #H, Certification of Grades Attained on the Podiatric Medical Licensing Examination for States (PMLEXIS) - revised June, 1997.

Form #I, National Board of Podiatric Medical Examiners request for scores on Part I and II - revised June, 1997.

Form HRB-30-061, Requirements and Instructions for an Intern/Resident License - revised July, 1997.

Intern/Resident Form #A, Memorandum from Associate Dean of Graduate Medical Education - revised July, 1997.

Intern/Resident, Form #B, Certificate of Professional Education - revised July, 1997.

Instructions for Completing an Application for a Limited License to Practice Medicine as a Full-time Faculty Member or as a Full-time Fellow - revised 8/99.

Form DHP-030-056, Application for a Limited License to Practice Medicine as a Full-time Faculty Member or as a Full-time Fellow - revised January, 1998.

Form #G - Request for Status Report of Education Commission for Foreign Medical Graduates Certification - revised October, 1997.

Instructions for a Licensure to Practice as a Physician Acupuncturist - revised March, 1997.

Application for a License to Practice Acupuncture - revised July, 1997.

Renewal Notice and Application - revised July, 1997

Virginia Physician Profile - revised November, 1999.

Virginia Podiatrist Profile - revised November, 1999.

# VIRGINIA PHYSICIAN PROFILE

Licensure Name:

Licensure Status:           Active           (See disciplinary action)

License # :   Medical Doctor 0101-  
              Osteopathic Doctor 0102-

\* Primary Practice Address:   Street, City, State, Zip  
                                  Approximate % Time at Location             
Variable                       

\* Secondary Practice Address: Street, City, State, Zip  
                                  Approximate % Time at each location

1.	<input type="checkbox"/>
2.	<input type="checkbox"/>
3.	<input type="checkbox"/>
4.	<input type="checkbox"/>
5.	<input type="checkbox"/>
6.	<input type="checkbox"/>

Please confirm current office hours.

Original License Date:       Month       Day       Year

License Expiration Date:       Month       Day       Year

## Education

Medical (osteopathic) school  
Degree  
Year Obtained

## \* Graduate Medical Education

Years of graduate medical education  
Specialty  
Residency  
Fellowship

## \*Board Certification (ABMS or ABOMS approved)

Name of Board  
Date originally certified  
None



\* Number of Years in Active Clinical Practice

(Post-training in the United States or Canada) \_\_\_\_\_

(Post-training outside the United States or Canada) \_\_\_\_\_

\* Specialty area in which the physician practices

- |                                      |                          |                          |
|--------------------------------------|--------------------------|--------------------------|
| Allergy and immunology               |                          | <input type="checkbox"/> |
| Anesthesiology                       | <input type="checkbox"/> |                          |
| Colon and rectal surgery             |                          | <input type="checkbox"/> |
| Dermatology                          | <input type="checkbox"/> |                          |
| Emergency medicine                   |                          | <input type="checkbox"/> |
| Family practice                      | <input type="checkbox"/> |                          |
| General medicine                     | <input type="checkbox"/> |                          |
| Internal medicine                    | <input type="checkbox"/> |                          |
| Medical genetics                     | <input type="checkbox"/> |                          |
| Neurological surgery                 |                          | <input type="checkbox"/> |
| Neurology                            | <input type="checkbox"/> |                          |
| Nuclear medicine                     | <input type="checkbox"/> |                          |
| Obstetrics and gynecology            |                          | <input type="checkbox"/> |
| Gynecology only                      |                          | <input type="checkbox"/> |
| Ophthalmology                        | <input type="checkbox"/> |                          |
| Orthopedic surgery                   |                          | <input type="checkbox"/> |
| Otolaryngology                       | <input type="checkbox"/> |                          |
| Pathology                            | <input type="checkbox"/> |                          |
| Pediatrics                           | <input type="checkbox"/> |                          |
| Physical medicine and rehabilitation |                          | <input type="checkbox"/> |
| Plastic surgery                      |                          | <input type="checkbox"/> |
| Preventive medicine                  |                          | <input type="checkbox"/> |
| Psychiatry                           | <input type="checkbox"/> |                          |
| Radiology                            | <input type="checkbox"/> |                          |
| Surgery                              | <input type="checkbox"/> |                          |
| Thoracic surgery                     |                          | <input type="checkbox"/> |
| Urology                              | <input type="checkbox"/> |                          |
| Other (please list)                  |                          | <input type="checkbox"/> |
| 1.                                   |                          |                          |
| 2.                                   |                          |                          |

\* Insurance or Managed Care Plans Accepted

Name(s)	Accepting new patients under the plan?		
1.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
2.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
3.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
4.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
5.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
6.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
7.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
8.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
9.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
10.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>

None

\* Hospital Affiliations

- 1.
- 2.
- 3.

\* Medical School Faculty Appointment(s)

Years  
Academic Rank  
Institution

\* Publications in last five years (up to 10)

Author(s) (HTML Links)	Title Publication	Volume	Page	Year
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\* Access to Translating Services YES  NO

Call office for details

Foreign language (s) spoken in the practice

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\* Virginia Medicaid Accepted YES  NO  Call office for details

Physician is accepting new Medicaid patients YES  NO

Malpractice Information (last 10 years)

Paid	Judgment NO	Settlement NO
Date	1. <input type="checkbox"/>	1. <input type="checkbox"/>
	2.	2.

Amount: Above Average

Average  
Below Average

Number of practitioners with this same specialty in state:  
% with paid claims:

Final Disciplinary Action:

Entity Taking action	Date	Final Action
1.		
2.		
3.		

\* Additional Information on Practitioner Competence

Continuing Education  
Subspecialties  
Honors  
Awards

**\* These items have been self-reported by the practitioner and can be changed by the practitioner.**

**VIRGINIA PODIATRIST PROFILE**

Licensure Name:

Licensure Status: Active (See disciplinary action)

License #: Podiatric Doctor 0103-

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\* Primary Practice Address: Street, City, State, Zip   
Approximate % Time at Location   
Variable

\* Secondary Practice Address: Street, City, State, Zip  
Approximate % Time at each location  
1.   
2.   
3.   
4.   
5.   
6.

Please confirm current office hours.

Original License Date: Month Day Year

License Expiration Date: Month Day Year

Education  
Podiatric school  
Degree  
Year Obtained

\* Graduate Podiatric Education  
Years of graduate podiatric education  
Specialty  
Residency  
Fellowship

\*Board Certification (American Board of Podiatric Surgery)  
Yes  Date originally certified \_\_\_\_\_ No

\* Number of Years in Active Clinical Practice  
(Post-training in the United States or Canada) \_\_\_\_\_

(Post-training outside the United States or Canada) \_\_\_\_\_

\* Specialty area in which the podiatrist practices (please list)

- 1.
- 2.

\* Insurance or Managed Care Plans Accepted

Name(s)	Accepting new patients under the plan?		
1.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
2.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
3.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
4.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
5.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
6.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
7.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
8.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
9.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
10.	YES	<input type="checkbox"/>	NO <input type="checkbox"/>

None

\* Hospital Affiliations

- 1.
- 2.
- 3.
- 4.

\* Podiatric School Faculty Appointment(s)

Years  
Academic Rank  
Institution

\* Publications in last five years (up to 10)

Author(s) (HTML Links)	Title Publication	Volume	Page	Year
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\* Access to Translating Services YES  NO   
Call office for details   
Foreign language (s) spoken in the practice

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\* Virginia Medicaid Accepted YES  NO  Call office for details   
Podiatrist is accepting new Medicaid patients YES  NO

Malpractice Information (last 10 years)

Paid Judgment NO  Settlement NO

**18 VAC 85-20-10 et seq.**  
**Board of Medicine**

Date	1.	1.
	2.	2.

Amount: Above Average  
Average  
Below Average

Number of practitioners with this same specialty instate:  
% with paid claims:

**Final Disciplinary Action:**

Entity Taking action	Date	Final Action
1.		
2.		
3.		

**\* Additional Information on Practitioner Competence**

Continuing Education  
Subspecialties  
Honors  
Awards

**\* These items have been self-reported by the practitioner and can be changed by the practitioner.**

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