DC HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

SURGICAL ASSISTANTS (SA)
REINSTATEMENT APPLICATION

Please note, if your license expired more than five (5) years from the date of this application then you must submit an application for a new license.

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to ***DC Code 22-2405***. **YOU MUST INITIAL EACH PAGE OF THE APPLICATION.**

If you have any questions, call HRLA Customer Service at **(877) 672-2174, Monday through Friday, 8:30AM to 4:00PM EST.**

SECTION 1: LICENSURE TYPE & FEES

Professional Designation:	**Application Type:**
☐ Surgical Assistant	☐ Reinstatement ($374.00)

SECTION 2: APPLICANT INFORMATION

First Name:	**MI:**	**Last Name:**
Date of Birth:	**Gender:** ☐ Male ☐ Female	**SSN:**

Race & Ethnicity (Optional):

☐ American Indian/Alaskan Native
☐ Asian/South Asian
☐ Black/African American
☐ Caucasian/White
☐ Native Hawaiian or Other Pacific Islander
☐ Hispanic or Latino
☐ Choose Not to Disclose
☐ Other: _____

Language(s) Spoken (Other than English):

☐ Spanish ☐ Vietnamese ☐ French
☐ Tagalog ☐ Amharic ☐ Mandarin
☐ Cantonese ☐ Russian ☐ German
☐ Korean ☐ Other: _____

SECTION 3: OTHER NAME(S) USED

If your name has changed at any point since you have taken any exams or attended college or university, you must provide a copy of a legal name change document for each time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

First Name:	**MI:**	**Last Name:**
First Name:	**MI:**	**Last Name:**
First Name:	**MI:**	**Last Name:**

SECTION 4: MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☐ **HOME ADDRESS** ☐ **BUSINESS ADDRESS**

SECTION 5: HOME ADDRESS		
A P.O. Box may NOT be used for an address. Home address information will NOT be made available to the public.		
Current Home Address:		
City:	**State:**	**Zip Code:**
Phone Number:	**Email Address:**	

SECTION 6: BUSINESS ADDRESS(ES)		
A P.O. Box may NOT be used for an address. Business address information WILL be made available to the public.		
Current Business Address #1:	**Phone Number:**	
City:	**State:**	**Zip Code:**
Phone Number:	**Email Address:**	
Current Business Address #2:	**Phone Number:**	
City:	**State:**	**Zip Code:**
Phone Number:	**Email Address:**	

IMPORTANT MESSAGE RE: UPDATING CONTACT INFORMATION

Licensees are required to update changes to their name, home address or business address within thirty (30) days of the change. Failure to do so may result in disciplinary action. It is imperative that you update your information in writing, either via mail or email, to the point of contact listed below:

Attn.: District of Columbia Board of Medicine
899 N. Capitol St. NE, 2nd Floor
Washington, DC 20002
E: dcbomed@dc.gov

SECTION 7: WORK EXPERIENCE			
List **ALL** work experience covering the five (5) year period prior to the submission of the application. Explain all gaps greater than three (3) months. Use additional sheets if necessary.			
Employer #1 Name:	**Start Date:**	**End Date:**	**Reason for Leaving:**
City:	**State:**		**Country (if not the United States):**
Employer #2 Name:	**Start Date:**	**End Date:**	**Reason for Leaving:**
City:	**State:**		**Country (if not the United States):**

Employer #3 Name:	**Start Date:**	**End Date:**	**Reason for Leaving:**
City:	**State:**		**Country (if not the United States):**
Employer #4 Name:	**Start Date:**	**End Date:**	**Reason for Leaving:**
City:	**State:**		**Country (if not the United States):**
Employer #5 Name:	**Start Date:**	**End Date:**	**Reason for Leaving:**
City:	**State:**		**Country (if not the United States):**
Employer #6 Name:	**Start Date:**	**End Date:**	**Reason for Leaving:**
City:	**State:**		**Country (if not the United States):**

SECTION 8: OTHER SURGICAL ASSISTANT LICENSES

List all states and jurisdictions in which you have **EVER** held a surgical license, regardless of status. Verifications should be provided from the issuing jurisdiction(s) for each license. For license type, indicate whether it was a full license, a temporary license, a training license, or any other type of license issued to you. Use additional sheets if necessary.

Jurisdiction #1:	**License Type:**	**Issue Date:**	**Exp. Date:**	**License Number:**
Jurisdiction #2:	**License Type:**	**Issue Date:**	**Exp. Date:**	**License Number:**
Jurisdiction #3:	**License Type:**	**Issue Date:**	**Exp. Date:**	**License Number:**
Jurisdiction #4:	**License Type:**	**Issue Date:**	**Exp. Date:**	**License Number:**
Jurisdiction #5:	**License Type:**	**Issue Date:**	**Exp. Date:**	**License Number:**
Jurisdiction #6:	**License Type:**	**Issue Date:**	**Exp. Date:**	**License Number:**

SECTION 9: CERTIFICATION(S)

List all surgical assistant certifications you have ever held with the National Surgical Assistant Association (NSAA) or the American Board of Surgical Assistants (ABSA). List certification in reverse chronological order, beginning with the most recent.

Certification #1: ☐ National Surgical Assistant Association (NSAA) ☐ American Board of Surgical Assistants (ABSA) ☐ National Commission for the Certification of Surgical Assistants (NCCSA)	**Start Date:**	**End Date:**
Certification #2: ☐ National Surgical Assistant Association (NSAA) ☐ American Board of Surgical Assistants (ABSA) ☐ National Commission for the Certification of Surgical Assistants (NCCSA)	**Start Date:**	**End Date:**
Certification #3: ☐ National Surgical Assistant Association (NSAA) ☐ American Board of Surgical Assistants (ABSA) ☐ National Commission for the Certification of Surgical Assistants (NCCSA)	**Start Date:**	**End Date:**

SECTION 10: EXPLANATION OF NON-RENEWAL

Provide a written explanation for why you did not renew your license, and why you are now attempting to reinstate your license. Use additional sheets if necessary.

SECTION 11: REQUIRED SCREENING QUESTIONS

Please answer questions 1 through 15 by placing an "X" in the appropriate boxes. If you answer "Yes" to any question, you must provide full information and complete details on a separate sheet of paper, as well as attach copies of all relevant documents such as final court orders or peer review panel decisions. Failure to provide relevant information will delay the application processing time.

1.	Have you ever been arrested, charged, convicted, pled guilty to, or pled no contest to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor, including driving under the influence or while impaired, but excluding minor traffic violations?	☐ Yes ☐ No
2.	Have you been a defendant or respondent to a claim for damages or a malpractice action? If you answer "Yes", please complete the Malpractice Claims Form and submit it along with all relevant court documents (e.g., Complaint, Answer, and Final Order/Decision). A separate Malpractice Claims Form MUST be completed for each malpractice case.	☐ Yes ☐ No
3.	Have you ever voluntarily surrendered a license or registration certificate, or allowed it to lapse, after formal charges had been brought against you or while you were under investigation?	☐ Yes ☐ No
4.	Have you ever surrendered your clinical privileges, voluntarily or involuntarily, or had your clinical privileges denied, revoked, or suspended at any hospital or health care facility?	☐ Yes ☐ No
5.	Have you ever been terminated or resigned, voluntarily or involuntarily, from a clinical or professional training program for any reason?	☐ Yes ☐ No
6.	Has any licensing authority, in any healthcare field, taken adverse action against your license or privileges or informed you of any pending charges?	☐ Yes ☐ No
7.	Has any licensing authority, health facility, or peer review board, in any healthcare field, informed you of any pending charge(s) or investigation(s) against you?	☐ Yes ☐ No
8.	Are you presently now, or have you ever been, under a corrective action plan imposed by an employer, medical facility or educational program?	☐ Yes ☐ No
9.	Do you have a medical condition or have you become aware of any medical condition that impairs or limits your ability to practice your profession?	☐ Yes ☐ No
10.	Have you ever engaged in any conduct that either indicated an impairment, or actually impaired, your ability to practice your profession?	☐ Yes ☐ No
11.	Have you ever entered into a monitoring program for purposes of monitoring your abuse of alcohol, drugs, or other controlled substances?	☐ Yes ☐ No
12.	Have you ever entered into a monitoring program for purposes of monitoring your professional behavior including recordkeeping, billing, boundaries, quality of care or any other matter related to the practice of your profession?	☐ Yes ☐ No
13.	Within the last ten (10) years have you voluntarily resigned, been asked to resign, terminated, or disciplined by any employer?	☐ Yes ☐ No
14.	Have you ever withdrawn a license application or have you been denied a license or denied the privilege of taking a license examination by any professional licensing board or agency?	☐ Yes ☐ No
15.	Have you ever been excluded from any federal or state run insurance program, including Medicare and/or Medicaid?	☐ Yes ☐ No

SECTION 12: CLEAN HANDS

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Requirement

Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed to revoke your license or permit for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.

As of this date, do any of the below statements apply to you:

- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 31, Chapter 24 (The Compulsory/No-Fault Motor Vehicle Insurance Act of 1982);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 3 (Department of For-Hire Vehicles Establishment Act of 1985);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 15 (Registration of Motor Vehicles);
- I owe more than $100 in fines, penalties, or interest assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication Act of 1978);
- I owe more than $100 in fines, penalties, or interest assessed by another jurisdiction; provided, that a reciprocity agreement is in effect between the jurisdiction and the District;
- I owe more than $100 in past due taxes;
- I owe more than $100 in any outstanding fines, penalties, or interest due to the District of Columbia;
- I owe any amount of past due District of Columbia Water and Sewer Authority service fees;
- I owe any amount of a vehicle conveyance fee pursuant to D.C. Official Code Title 50, Chapter 23;
- I owe any amount of past due fines, penalties, or past due restitution on behalf of an employee due to a violation of D.C. Official Code Title 32, Chapters 1A, 10, 13 or Title 2, Subchapter X-A; or
- I have failed to file required District tax returns.

☐ Yes ☐ No

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861, et seq.).

SECTION 13: DOCUMENT CHECKLIST

Please indicate the supporting documents you have included with this package or requested to be sent to the DC Board of Medicine. Please keep a photocopy of any submitted documents for your records, as they will not be returned.

☐ **Authorization to Release Information Form**

The Board cannot discuss the status or details of your application with a third party, without a signed release from you authorizing the Board and its staff to communicate said matters.

☐ **Two (2) Recent and Identical Passport Type Photos of the Applicant's Face (approx. 2" x 2") with the Applicant's Name Printed on the Back**

The photo must be original photos and cannot be computer-generated copies, or paper copies.

☐ **One (1) Photocopy of a Current Government Issued Photo ID**

☐ **Criminal Background Check (CBC)**

If a CBC was already completed, a new CBC is not required. For anyone needing to undergo a new CBC, the CBC form and instructions can be accessed at https://dchealth.dc.gov/node/120532 or contact the CBC unit at (877) 783-4187.

☐ **Verification(s) of Licensure**

Verifications should be provided from the issuing jurisdiction(s) for each license identified in Section 10 of the application.

☐ **Proof of Continuing Education (CE)**

Must submit proof of having completed fifty (50) hours of CE for the two (2) year period immediately preceding the date of application. In lieu of submitting the above, an applicant may submit proof of holding a current valid certification from the NSAA, ABSA, and/or the NCCSA.

☐ **Malpractice Claims Form (if responded "Yes" to screening question #2)**

Must submit all relevant court documentation (e.g., Complaint, Answer, and Final Order/Decision).

☐ **National Practitioner Databank (NPDB) Self Query Report**

The Self-Query Report must be requested from the NBPD no more than thirty (30) days prior to submission of the application.

SECTION 14: PAYMENT AND MAILING INFORMATION.

Make your check or money order payable to "**DC Treasurer**". A charge of sixty-five dollars ($65.00) will be imposed for dishonored checks (Public Law 89-208). **FEES ARE NON-REFUNDABLE.**	Mail your completed application and check to: **Board of Medicine – SA Reinstatement Application** **HRLA 1** **PO Box 37801** **Washington, DC 20013**

SECTION 15: APPLICANT'S AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

SIGNATURE OF APPLICANT:	**DATE:**

REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at https://oig.dc.gov.