

Agenda Item #24.



BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECNNICIANS
[2535 Capitol Oaks Drive, Suite 205, Sacramento, CA 95833-2945
Phone (916) 263-7800 Fax (916) 263-7855 Web www.bvnpt.ca.gov



DATE November 13, 2015

TO Board Members

FROM 
Rocio Llamas, Manager
Enforcement Division

SUBJECT Revised Petition for Reinstatement of License Application Form

Purpose:

Attached for review and possible action is the revised Petition for Reinstatement of License Application Form (Petition Application).

Background:

The current Petition Application dated June 7, 2012, is used by Board staff to provide to individuals whose licenses have been revoked or surrendered, who may petition the Board for reinstatement.

At the November 2014 Board Meeting, the Board requested this Petition Application be revised. Board staff revised the form and presented it to the Board for review and possible action at the August 21, 2015, Board Meeting. At that time, the Board requested additional edits to the form, and motioned to place this item on the November 2015 Board Meeting agenda for consideration.

The Board requested staff conduct additional research regarding the disclosure of medication question on the form: "*Are you currently taking prescribed and/or over the counter medication?*" The Board also requested staff survey other Boards to determine if their Petition for Reinstatement of License Application Form contains verbiage regarding the disclosure of medication.

Analysis:

Including this board, the Department of Consumer Affairs (DCA) has a total of 20 healing arts boards. The other 19 healing arts Boards were contacted and surveyed regarding the disclosure of medication question on their Petition Application. The following are the results of the survey:

Of the 19 healing arts Boards surveyed, only one Board's Petition Application asks the question regarding disclosure of medication (California Board of Occupational Therapy). That Board modeled their Petition Application after our Board's form.

Fifteen Boards do not ask the question regarding disclosure of medication on their Petition Application. Three Boards did not respond to this survey.

While conducting the survey, many of these Boards stated that they were advised by their DCA Legal Counsel not to ask the disclosure of medication question on their form.

Recommendation:

1. The Board adopt the revised Petition for Reinstatement of License Application Form removing the disclosure of medication question.

Attachments:

- A. Revised Petition for Reinstatement of License Application for Board review and possible action.
- B. Revision two of Petition for Reinstatement of License Application Form presented to the Board Members at the August 21, 2015, Board Meeting.
- C. Revision one of Petition for Reinstatement of License Application Form edited (redlined) by Board Member Eric Mah.
- D. Current Petition for Reinstatement of License Application. (Dated: 06/07/12)
- E. Samples of Other Healing Arts Boards' Petition Application Forms: 1) Board of Chiropractic Examiners, 2) Dental Board of California, 3) Medical Board of California, and 4) Physical Therapy Board of California.



Agenda Item #24. Attachment A.

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

Board of Vocational Nursing and Psychiatric Technicians

2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833-2945

Phone 916-263-7800 Fax 916-263-7855 www.bvnpt.ca.gov



Revised Petition for Reinstatement of License Application for Board review and possible action.



PETITION FOR REINSTATEMENT OF LICENSE

(PLEASE TYPE OR PRINT ALL ANSWERS)

NOTE: Pursuant to Government Code section 11522, the Board shall give notice to the Attorney General of the filing of the petition and the Attorney General shall be afforded an opportunity to present oral and written argument before the agency itself.

1. Name: _____ License Number: _____	
Address: _____ (street address)	

(city, state, and zip code)	
Telephone No.:(_____) _____	Email Address: _____
Date License Was Originally Issued: _____	
Date License Was Revoked or Surrendered: _____	
Have You Ever Been Licensed Under Any Other Names(s)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please list:	

2. Will You Be Represented By An Attorney? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name of Attorney: _____	Telephone No: (_____) _____
Address: _____ (street address)	

(city, state, and zip code)	
3. Will You Need A Translator, Sign Language Interpreter, or a Special Accomodation? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please indicate which language (for a translator) or what type of accommodation you will need:	

4. Please provide a detailed explanation the reason why your license was revoked or surrendered:

5. Since the date of your revocation or surrender, have you been convicted of, pled guilty to, or pled nolo contendere to ANY offense in the United States or a foreign country? Yes No

This includes every citation, infraction, misdemeanor and/or felony, excluding traffic violations under \$1,000 which do not involve alcohol, dangerous drugs or controlled substances. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code Sections 11357(b), (c), (d), (e), or Section 11360(b) which are two years or older should NOT be reported. Convictions that were later dismissed pursuant to section 1203.4, 1203.4a or 1203.41 of the California Penal Code or equivalent non-California law MUST be disclosed. If you have obtained a dismissal of your conviction(s) pursuant to Penal Code sections 1203.4, 1203.41, or 1203.41, please submit a certified copy of the court order dismissing the conviction(s) with your application.

If yes, please provide the violation(s) below.

Date: _____ Violation: _____ Date: _____ Violation: _____

Date: _____ Violation: _____ Date: _____ Violation: _____

6. CRIMINAL CONVICTION: (Complete this section if applicable)

Name of probation/parole officer: _____

Telephone number of probation/parole officer: (____) _____

Date criminal probation was completed or will be completed: _____

Are you in compliance with the terms and conditions of your criminal probation? Yes No

Please attach Proof of Completion of Probation, Parole or status of compliance.

Please provide a detailed explanation, if you are out of compliance with the terms of your criminal probation:

Pursuant to Business and Profession Code Sections 2878.7 (e) (VN) and 4524(e) (PT), no petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole or subject to an order of registration pursuant to Section 290 of the Penal Code. No petition shall be considered while there is an accusation or petition to revoke probation pending against the petitioner.

7. Since the date of your revocation or surrender, are you subject to an order of registration pursuant to Section 290 of the Penal Code? Yes No

ADDITIONAL LICENSURE:

8. Do you possess a license and/or certificate to practice nursing or other healthcare related duties in the State of California or any other state? Yes No

If yes, please list the state(s) where you are licensed, the license number and the current status of the license.

Name of State	License Number	Type of License	Date of Expiration	Status
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9. Pursuant to B&P 2878.7(e) and 4524(e), are there any disciplinary actions pending against the above licenses? Yes No

EMPLOYMENT STATUS/HISTORY:

10. List all employers for the past seven (7) years. Use additional paper if necessary. Provide recent work performance evaluations and/or a letters of recommendation from each of the employers listed below. Provide letters of reference or other documentation addressing your responsibilities, job performance, attendance, attitude, appearance, communication skills, interpersonal skills, etc.

Current Employer:

Employer: _____ Address: _____
(street, city, state, and zip code)

Telephone Number: (_____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities:

Reason for Leaving:

#2

Employer: _____ Address: _____
(street, city, state, and zip code)

Telephone Number: (_____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities:

Reason for Leaving:

#3

Employer: _____ Address: _____
(street, city, state, and zip code)

Telephone Number: (_____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities:

Reason for Leaving:

EDUCATION:

11. Have you completed or are you currently taking any continuing education courses related to nursing or other healthcare issues? Yes No

List the coursework below and attach proof of completion or attendance/transcripts:

Coursework Assigned	Name of Provider	Hours/Units	Date Completed
---------------------	------------------	-------------	----------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. Have you read any books or articles pertaining to your area of professional practice since the date of your revocation or surrendered? Yes No

If yes, please list the name of the book or periodical in which the article appeared and the name of the Author.

Name of Book/Periodical

Author

Title of Article

13. If the Board grants your Petition to reinstate your license, please describe your plans for continuing education:

REHABILITATION PROGRAM: (Complete this section if applicable)

14. Are you currently attending a rehabilitation program (CHECK ONE)? Alcohol Drug No

If no, have you completed an alcohol/drug rehabilitation program? Yes No

If yes, please provide the following information:

Date entered program: _____ Date completed program: _____

Name of Program: _____ Name of Counselor: _____

Address: _____
(street name)

(city, state, and zip code)

Telephone Number: (_____) _____

Check the type of rehabilitation program: Residential In-patient Out-patient

Please attach Proof of Completion of program if applicable, and a description of the services provided.

CHEMICAL DEPENDENCY SUPPORT GROUP: (Complete this section if applicable)

Please attach a letter from your Sponsor and/or others who can testify to your attendance, participation and rehabilitation efforts.

15. Do you currently attend **and** participate in a chemical dependency program, (i.e. Alcoholics Anonymous, Narcotics Anonymous, or a Nurse Support Group):

Yes, currently attending No, attended in the past but no longer No, never attended

State Group Name (as applicable): _____

If no, please explain why you no longer attend or why you have never attended:

How many meetings per week do (or did) you attend _____

Do you have a sponsor currently? Yes No

What is your sobriety date: _____

Have you abstained from the use of alcohol and/or drugs since your date of sobriety? Yes No

If no, when was the last time you used drugs or alcohol and what were the circumstances?:

THERAPY: (Complete this section if applicable)

16. Are you currently receiving counseling or treatment by a psychologist, psychiatrist, or therapist?

Yes, currently receiving counseling/treatment No, in the past but no longer No, never

If yes, please provide a letter from your Psychiatrist, Psychologist or Therapist and/or Group Facilitator Regarding Your Attendance, Participation and Progress.

Please provide your Psychiatrist, Psychologist or Therapist and/or Group Facilitator's information:

Name of Doctor/Therapist: _____ Title: _____

Address: _____
(street)

(city, state, and zip code)

Telephone Number: (_____) _____

If no, please explain why you no longer attend or why you have never attended

On average, how often do you attend _____ weekly _____ monthly Not Applicable

Do you currently attend and participate in group therapy?

Yes, currently attending No, in the past but no longer No, never

Name of the group: _____

How often do you attend the group meetings _____ weekly _____ monthly Not Applicable

How has your participation in individual and/or group counseling benefited you?

FITNESS TO PRACTICE IN YOUR LICENSED CAPACITY:

17. Are you currently under the care of a psychiatrist, physician, dentist, or other healthcare professional for a condition that could impact your skills or abilities as a licensed vocational nurse or psychiatric technician? Yes No

If yes, what is the reason for your treatment:

18. Do you have any physical and/or mental conditions that would preclude you from performing all duties of a licensed vocational nurse or psychiatric technician? Yes No

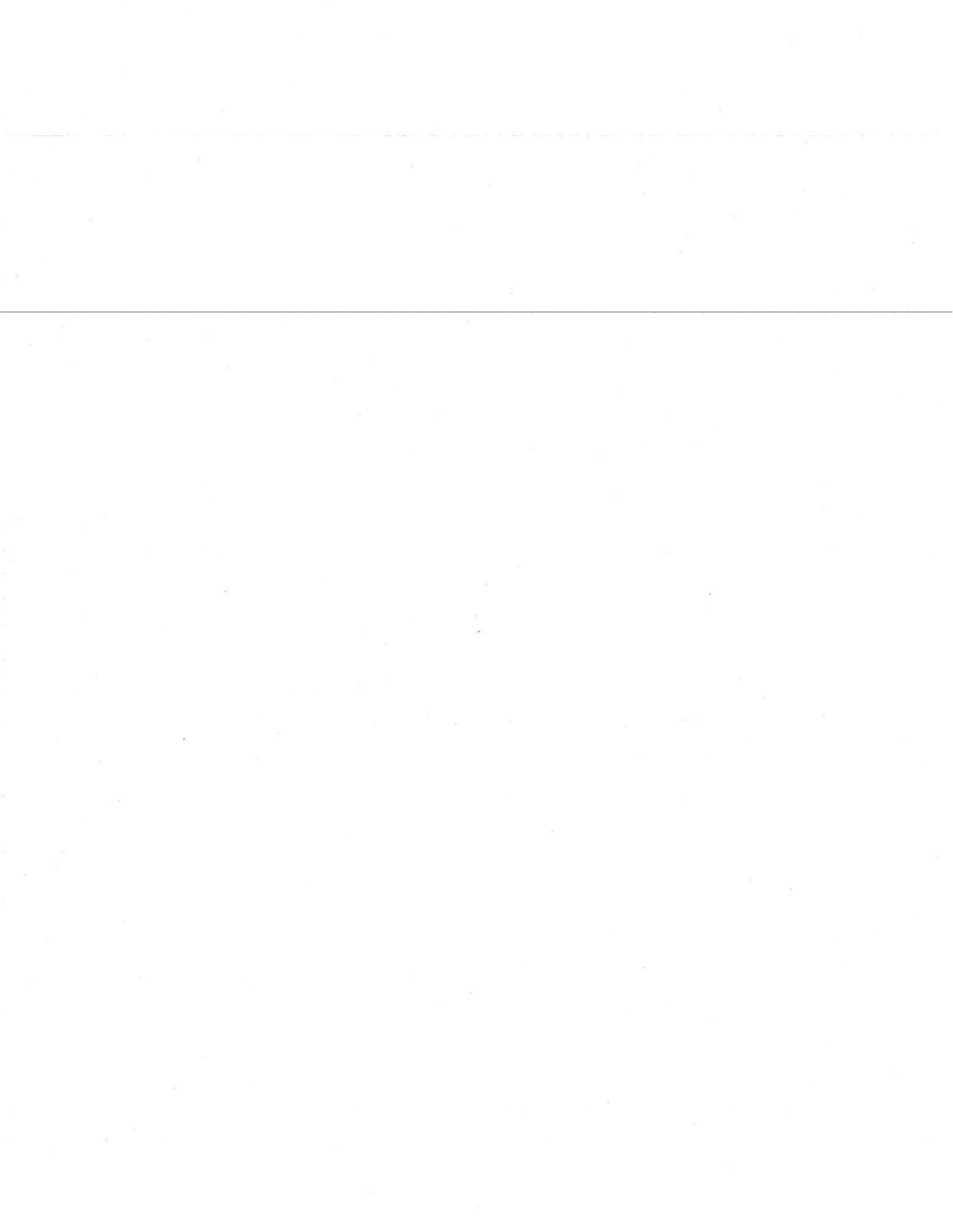
If yes, please provide a detailed explanation:

19. **ADDITIONAL INFORMATION:** List ANY activities which you have used to prevent a reoccurrence of the violation(s) that led to the revocation or surrender of your license. (Examples: areas of personal growth, continued education not related to your license, exercise programs, voluntary associations, etc.) **Please attach any documentation to support your response.**

20. **HAVE YOU PREVIOUSLY PETITIONED THE BOARD FOR REINSTATEMENT OF YOUR LICENSE?:**

Yes No

If yes, please provide the attendance dates of the Board Hearings.





Agenda Item #24. Attachment B.

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

Board of Vocational Nursing and Psychiatric Technicians

2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833-2945

Phone 916-263-7800 Fax 916-263-7855 www.bvnpt.ca.gov



Revision two of Petition for Reinstatement of License Application Form presented to the Board Members at the August 21, 2015, Board Meeting.



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Board of Vocational Nursing and Psychiatric Technicians
2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833-2945
Phone 916-263-7800 Fax 916-263-7855 www.bvnpt.ca.gov

Agenda Item #15.



DATE: August 14, 2015

TO: Board Members

FROM:

Rocio Lamas
Rocio Lamas
Enforcement Program Manager

SUBJECT: Revised Petition for Reinstatement of License Application Form

Attached for review and possible action is a revised Petition for Reinstatement of License Application Form.



PETITION FOR REINSTATEMENT OF LICENSE

(PLEASE TYPE OR PRINT ALL ANSWERS)

NOTE: Pursuant to Government Code section 11522, the Board shall give notice to the Attorney General of the filing of the petition and the Attorney General shall be afforded an opportunity to present oral and written argument before the agency itself.

Name: _____ License Number: _____			
Address: _____ (street, city, state, and zip code)			
Telephone No.: (____) _____			
Date License Was Originally Issued: _____	Date License Was Revoked: _____		
Have You Ever Been Licensed Under Any Other Names(s)? Yes <input type="checkbox"/> No <input type="checkbox"/> Please List: _____ _____			
Will You Be Represented By An Attorney? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name of Attorney: _____	Telephone No: (____) _____		
Address: _____ (street, city, state, and zip code)			
Reason Why License Was Revoked or Surrendered: (Check All Applicable Boxes)			
<input type="checkbox"/> Drug Related	<input type="checkbox"/> Criminal Conviction	<input type="checkbox"/> Gross Negligence	<input type="checkbox"/> Other (Explain Below)
<input type="checkbox"/> Alcohol Related	<input type="checkbox"/> Patient Abuse	<input type="checkbox"/> Incompetence	
Explain Fully The Reason Your License Was Revoked or Surrendered: _____ _____ _____ _____ _____			

Since the date of your revocation or surrender, have you ever been convicted of, pled guilty to, or pled nolo contendere to ANY offense in the United States or a foreign country? Yes No

This includes every citation, infraction, misdemeanor and/or felony, excluding traffic violations under \$1,000 which do not involve alcohol, dangerous drugs or controlled substances. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code Sections 11357(b), (c), (d), (e), or Section 11360(b) which are two years or older should NOT be reported. Convictions that were later dismissed pursuant to section 1203.4, 1203.4a or 1203.41 of the California Penal Code or equivalent non-California law MUST be disclosed. If you have obtained a dismissal of your conviction(s) pursuant to Penal Code sections 1203.4, 1203.41, or 1203.41, please submit a certified copy of the court order dismissing the conviction(s) with your application.

If yes, please provide the violation(s) below.

Date: _____ Violation: _____ Date: _____ Violation: _____
Date: _____ Violation: _____ Date: _____ Violation: _____

Pursuant to Business and Profession Code Sections 2878.7 (e) (VN) and 4524(e) (PT), no petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole or subject to an order of registration pursuant to Section 290 of the Penal Code. No petition shall be considered while there is an accusation or petition to revoke probation pending against the petitioner.

Since the date of your revocation or surrender, are you subject to an order of registration pursuant to Section 290 of the Penal Code? Yes No

CRIMINAL CONVICTION: (Complete this section if applicable)

Attach Proof of Completion of Probation, Parole or Status of Compliance.

Name of probation/parole officer: _____

Telephone number of probation/parole officer: (_____) _____

Date criminal probation was completed or will be completed: _____

Are you in compliance with the terms and conditions of your criminal probation? Yes No

Explain fully if you are out of compliance with the terms of your criminal probation:

ADDITIONAL LICENSURE:

Do you possess a license and/or certificate to practice nursing or other healthcare related duties in the State of California or any other state? Yes No If yes, please list the state(s) where you are licensed, the license number and the current status of the license.

Name of State	License Number	Type of License	Date of Expiration	Status
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Pursuant to B&P 2878.7(e) and 4524(e), are there any disciplinary actions pending against the above licenses? Yes No

EMPLOYMENT STATUS/HISTORY:

List all employers for the past seven (7) years. Use additional paper if necessary. Provide recent work performance evaluations and/or a letters of recommendation from each of the employers listed below. Provide letters of reference or other documentation addressing your responsibilities, job performance, attendance, attitude, appearance, communication skills, interpersonal skills, etc.

Current Employer:

Employer: _____ Address: _____
(street, city, state, and zip code)

Telephone Number: (____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities:

Reason for Leaving:

#2

Employer: _____ Address: _____
(street, city, state, and zip code)

Telephone Number: (____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities:

Reason for Leaving:

#3

Employer: _____ Address: _____
(street, city, state, and zip code)

Telephone Number: (____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities:

Reason for Leaving:

EDUCATION: Attach Proof of Completion or Attendance/Transcripts

Have you completed or are you currently taking any continuing education courses related to nursing or other healthcare issues? Yes No

List the coursework below:

Coursework Assigned	Name of Provider	Hours/Units	Date Completed

Have you read any books or articles pertaining to your area of professional practice since the date of your revocation? Yes No

If yes, please list the name of the book or periodical in which the article appeared and the name of the Author.

Name of Book/Periodical	Author	Title of Article

If revocation or surrender of your license occurred within the last 4 years, describe your plans for continuing education, if your license is reinstated:

REHABILITATION PROGRAM: (Complete this section if applicable) Attach Proof of Completion of Program and a Description of the Services Provided.

Are you currently attending an alcohol or drug (CHECK ONE or BOTH) rehabilitation program? Yes No

If YES ABOVE, what is the date you entered into the program? _____

If NO ABOVE, have you completed an alcohol/drug rehabilitation program? Yes No

Date entered program: _____ Date completed program: _____

Name of Program: _____ Name of Counselor: _____

Address: _____
(street, city, state, and zip code)

Telephone Number: (_____) _____

Check the type of rehabilitation program: Residential In-patient Out-patient

CHEMICAL DEPENDENCY SUPPORT GROUP: (Complete if Applicable) Attach A Letter From Your Sponsor and/or Others Who Can Testify To Your Attendance, Participation and Rehabilitation Efforts.

What is your sobriety date: _____

Do you currently attend and participate in a chemical dependency program, (i.e. Alcoholics Anonymous, Narcotics Anonymous, or a Nurse Support Group):

Yes, currently attending No, attended in the past but no longer No, never attended

State Group Name (as applicable): _____

If NO, please clarify why you no longer attend:

How many meetings per week do (or did) you attend _____

Do you have a sponsor currently? Yes No

Have you abstained from the use of alcohol and/or drugs since your date of sobriety? Yes No

If your answer was no, when was the last time you used drugs or alcohol and what were the circumstances?:

THERAPY: (Complete if applicable) Attach a Letter From Your Psychiatrist, Psychologist or Therapist and/or Group Facilitator Regarding Your Attendance, Participation and Progress.

Name of Doctor/Therapist: _____ Title: _____

Address: _____
(street, city, state, and zip code)

Telephone Number: (_____) _____

Are you currently receiving counseling or treatment by a psychologist, psychiatrist, or therapist?
Yes, currently receiving counseling/treatment No, in the past but no longer No, never

If NO, please clarify why:

On average, how often do you attend _____ weekly _____ monthly Not Applicable

Do you currently attend and participate in group therapy?
Yes, currently attending No, in the past but no longer No, never

Name of the group: _____

How often do you attend the group meetings _____ weekly _____ monthly Not Applicable

How has your participation in individual and/or group counseling benefited you?

FITNESS TO PRACTICE IN YOUR LICENSED CAPACITY:

Are you currently under the care of a psychiatrist, physician, dentist, or other healthcare professional for a condition that could impact your skills or abilities as a licensed vocational nurse or psychiatric technician? Yes No

If your answer is yes, what is the reason for your treatment:

Do you have any physical and/or mental disabilities that would preclude you from performing all duties of a licensed vocational nurse or psychiatric technician? Yes No

If your answer is yes, please provide a detailed explanation:

Are you currently taking any prescribed and/or over the counter medication? Yes No

If yes, please list all medications, including dose, and their purpose:

ADDITIONAL INFORMATION: List **ANY** activities which you have used to prevent a reoccurrence of the violation(s) that led to the revocation or surrender of your license. (Examples: areas of personal growth, continued education not related to your license, exercise programs, voluntary associations, etc.) **Attach Any Documentation To Support Your Response**

HAVE YOU PREVIOUSLY PETITIONED THE BOARD FOR REINSTATEMENT OF YOUR LICENSE?:
Yes No If yes, please provide the attendance dates of the Board Hearings.

Agenda Item #24. Attachment C.



BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
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Revision one of Petition for Reinstatement of License Application Form
edited (redlined) by Board Member Eric Mah.



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Board of Vocational Nursing and Psychiatric Technicians
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PETITION FOR REINSTATEMENT OF LICENSE

(PLEASE TYPE OR PRINT ALL ANSWERS)

NOTE: Pursuant to Government Code section 11522, the Board shall give notice to the Attorney General of the filing of the petition and the Attorney General shall be afforded an opportunity to present oral and written argument before the agency itself.

Name: _____ License Number: _____
 Address: _____ Telephone No.: (____) _____
(street, city, zip code)
 Date License Was Originally Issued: _____ Date License Was Revoked: _____
 Have You Ever Been Licensed Under Any Other Names(s)? Yes No Please List _____

Will You Be Represented By An Attorney? Yes No
 Name of Attorney: _____ Telephone No: (____) _____
 Address: _____
(street, suite number, city, zip code)

Reason Why License Was Revoked: (Check All Applicable Boxes)

Drug Related Criminal Conviction Gross Negligence Other (Explain Below)
 Alcohol Related Patient Abuse Incompetence

Explain Fully The Reason Your License Was Revoked: _____

Since the date of your revocation, have you been convicted of, or pled nolo contendere to, any violation of any law of any state in the United States or a foreign country? ~~(you must include, but is not limited to, traffic tickets/citations, infractions, misdemeanors, and felonies)~~ ALL felonies, misdemeanors, infractions, and traffic citations? Yes No

If yes, please provide the violation(s) below.

Date: _____ Violation: _____ Date: _____ Violation: _____
 Date: _____ Violation: _____ Date: _____ Violation: _____

06/07/12 DRAFT 5/15/2015

EMPLOYMENT STATUS/HISTORY:

Have you been employed since the date of your revocation?: Yes No
If yes, is your employment related to the healthcare field?: Yes No

EMPLOYMENT HISTORY:

List all employers for the past seven (7) years. Use additional paper if necessary. Attach Provide a recent work performance evaluations and/or a letter of recommendations from each of the employers listed below. To strengthen your application, Ask each employer to include information regarding provide letters of reference or other documentation addressing your responsibilities, job performance, attendance, attitude, appearance, communication skills, interpersonal skills, etc.

Current Employer:

Employer: _____ Address: _____

Telephone Number: (____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities: _____

Reason for Leaving: _____

#2

Employer: _____ Address: _____

Telephone Number: (____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities: _____

Reason for Leaving: _____

#3

Employer: _____ Address: _____

Telephone Number: (____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities: _____

Reason for Leaving: _____

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ADDITIONAL LICENSURE

Do you possess a license and/or certificate to practice nursing or other healthcare related duties in the State of California or any other state? Yes No If yes, please list the state(s) where you are licensed, the license number and the current status of the license.

Name of State	License Number	Type of License	Date of Expiration	Status
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EDUCATION: Attach Proof of Completion or Attendance/Transcripts

Have you completed or are you currently taking any continuing education courses related to nursing or other healthcare issues? Yes No List the coursework below:

Coursework Assigned	Name of Provider	Hours/Units	Date Completed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you read any books or articles pertaining to your area of professional practice since the date of your revocation? Yes No If yes, please list the name of the book or periodical in which the article appeared and the name of the Author.

Name of Book/Periodical	Author	Title of Article
_____	_____	_____
_____	_____	_____
_____	_____	_____

If revocation of your license occurred within the last 4 years, what are describe your plans for continuing education if your license is reinstated

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REHABILITATION PROGRAM: (Complete this section if applicable) Attach Proof of Completion of Program and a Description of the Services Provided.

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Are you currently attending an alcohol or drug (CIRCLE ONE or BOTH) rehabilitation program? Yes No

If YES ABOVE, what is the DATE did you enter the program? _____

or

If NO ABOVE, have you completed an alcohol/drug rehabilitation program? Yes No

Date entered program: _____ Date program completed: _____

Name of Program: _____ Name of Counselor: _____

Address: _____ Telephone Number: _____

Circle the type of rehabilitation program: Residential In-patient Out-patient

Date entered program: _____ Date program completed: _____

CHEMICAL DEPENDENCY SUPPORT GROUP: (Complete if Applicable) Attach A Letter From Your Sponsor and/or Others Who Can Testify To Your Attendance, Participation and Rehabilitation Efforts.

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What is your sobriety date: _____

Do you currently attend and participate in a chemical dependency program, (i.e. Alcoholics Anonymous, Narcotics Anonymous, or a Nurse Support Group) Yes, currently attending No, attended in the past but no longer No, never attended

State Group Name (as applicable): _____

If NO, please clarify why you no longer attend _____

How many meetings per week do (or did) you attend _____ Do you have a sponsor currently? Yes No

Have you abstained from the use of alcohol and/or drugs since your date of sobriety? Yes No

If your answer was no, when was the last time you used drugs or alcohol and what were the circumstances: _____

THERAPY: (Complete if applicable) Attach a Letter From Your Psychiatrist, Psychologist or Therapist and/or Group Facilitator Regarding Your Attendance, Participation and Progress.

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Name of Doctor/Therapist: _____ Title: _____

Address: _____ Telephone Number: _____

Are you currently receiving counseling or treatment by a psychologist, psychiatrist, or therapist?

Yes, currently receiving counseling/treatment No, in the past but no longer No, never

If NO, please clarify why: _____

On average, how often do you attend _____ weekly _____ monthly Not Applicable

Do you currently attend and participate in group therapy? Yes, currently receiving attending No, in the past but no longer No, never

Yes No Name of the group: _____

How often do you attend the group meetings _____ weekly _____ monthly Not Applicable

How has your participation in individual and/or group counseling benefited you?

FITNESS TO PRACTICE IN YOUR LICENSED CAPACITY:

Are you currently under the care of a psychiatrist, physician, dentist, or other healthcare professional that could impact your skills or abilities as a licensed vocational nurse or psychiatric technician? Yes No

If your answer is yes, what is the reason for your treatment:

Do you have any physical and/or mental disabilities that would preclude you from performing all duties of a licensed vocational nurse or psychiatric technician? Yes No If your answer is yes, please provide a detailed explanation:

Are you currently taking any prescribed and/or over the counter medication? Yes No If your answer is yes, please list all medications including dose and their purpose.

CRIMINAL CONVICTION: (Complete this section if applicable)

Attach Proof of Completion of Probation, Parole or Status of Compliance.

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Name of probation/parole officer: _____

Telephone number of probation/parole officer: _____

Date criminal probation was completed or will be completed _____

Are you in compliance with the terms and conditions of your criminal probation? Yes No

Explain fully if you are out of compliance with the terms of your criminal probation _____

ADDITIONAL INFORMATION: List ANY activities which you have used to prevent a reoccurrence of the violation(s) that led to the revocation of your license. (Examples: areas of personal growth, continued education not related to your license, exercise programs, voluntary associations, etc.) **Attach Any Documentation To Support Your Response**

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HAVE YOU PREVIOUSLY PETITIONED THE BOARD FOR REINSTATEMENT OF YOUR LICENSE?

Yes No If yes, please provide the attendance dates of the Board Hearings.

WHY ARE YOU PETITIONING THE BOARD FOR REINSTATEMENT OF YOUR LICENSE?:

WHY SHOULD THE BOARD GRANT YOUR PETITION FOR REINSTATEMENT?:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Your Signature

Date

Agenda Item #24. Attachment D.



BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

Board of Vocational Nursing and Psychiatric Technicians

2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833-2945

Phone 916-263-7800 Fax 916-263-7855 www.bvnpt.ca.gov



Current Petition for Reinstatement of License Application. (Dated:
06/07/12)



PETITION FOR REINSTATEMENT OF LICENSE

(PLEASE TYPE OR PRINT ALL ANSWERS)

NOTE: Pursuant to Government Code section 11522, the Board shall give notice to the Attorney General of the filing of the petition and the Attorney General shall be afforded an opportunity to present oral and written argument before the agency itself.

Name: _____	License Number: _____		
Address: _____ <small>(street, city, zip code)</small>	Telephone No.: (____) _____		
Date License Was Originally Issued: _____	Date License Was Revoked: _____		
Have You Ever Been Licensed Under Any Other Names(s)? Yes <input type="checkbox"/> No <input type="checkbox"/> Please List _____			
Will You Be Represented By An Attorney? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name of Attorney: _____	Telephone No: (____) _____		
Address: _____ <small>(street, suite number, city, zip code)</small>			
Reason Why License Was Revoked: (Check All Applicable Boxes)			
<input type="checkbox"/> Drug Related	<input type="checkbox"/> Criminal Conviction	<input type="checkbox"/> Gross Negligence	<input type="checkbox"/> Other (Explain Below)
<input type="checkbox"/> Alcohol Related	<input type="checkbox"/> Patient Abuse	<input type="checkbox"/> Incompetence	
Explain Fully The Reason Your License Was Revoked: _____			

Since your revocation, have you been convicted of, or pled nolo contendere to, any violation of any law of any state in the United States or a foreign country (you must include ALL felonies, misdemeanors, infractions, and traffic citations)? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, please provide the violation(s) below.			
Date: _____	Violation: _____	Date: _____	Violation: _____
Date: _____	Violation: _____	Date: _____	Violation: _____

06/07/12

EMPLOYMENT STATUS:

Have you been employed since the date of your revocation?: Yes No

If yes, is your employment related to the healthcare field?: Yes No

EMPLOYMENT HISTORY:

List all employers for the past seven (7) years. Use additional paper if necessary. Attach a recent work performance evaluation and/or a letter of recommendation from each of the employers listed below. Ask each employer to include information regarding your responsibilities, job performance, attendance, attitude, appearance, communication skills, interpersonal skills, etc.

Current Employer:

Employer: _____ Address: _____

Telephone Number: (____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities: _____

Reason for Leaving: _____

#2

Employer: _____ Address: _____

Telephone Number: (____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities: _____

Reason for Leaving: _____

#3

Employer: _____ Address: _____

Telephone Number: (____) _____ Supervisor's Name: _____

Dates of Employment: _____ to _____ Your Job Title: _____

Responsibilities: _____

Reason for Leaving: _____

ADDITIONAL LICENSURE

Do you possess a license and/or certificate to practice nursing or other healthcare related duties in the State of California or any other state? Yes No If yes, please list the state(s) where you are licensed, the license number and the current status of the license.

Name of State	License Number	Type of License	Date of Expiration	Status
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EDUCATION: *Attach Proof of Completion or Attendance/Transcripts*

Have you completed or are you currently taking any continuing education courses related to nursing or other healthcare issues? Yes No List the coursework below:

Coursework Assigned	Name of Provider	Hours/Units	Date Completed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you read any books or articles pertaining to your area of professional practice since the date of your revocation? Yes No If yes, please list the name of the book or periodical in which the article appeared and the name of the Author.

Name of Book/Periodical	Author	Title of Article
_____	_____	_____
_____	_____	_____

What are your plans for continuing education if your license is reinstated _____

REHABILITATION PROGRAM: (Complete this section if applicable) Attach Proof of Completion of Program and a Description of the Services Provided.

Are you attending or have you completed an alcohol/drug rehabilitation program? Yes No

Name of Program: _____ Name of Counselor: _____

Address: _____ Telephone Number: _____

Circle the type of rehabilitation program: Residential In-patient Out-patient

Date entered program: _____ Date program completed: _____

CHEMICAL DEPENDENCY SUPPORT GROUP: (Complete if Applicable) Attach A Letter From Your Sponsor and/or Others Who Can Testify To Your Attendance, Participation and Rehabilitation Efforts.

What is your sobriety date: _____

Do you attend **and** participate in a chemical dependency program, (i.e. Alcoholics Anonymous, Narcotics Anonymous, or a Nurse Support Group) Yes No Group Name: _____

How many meetings per week do you attend _____ Do you have a sponsor? Yes No

Have you abstained from the use of alcohol and/or drugs since your date of sobriety? Yes No

If your answer was no, when was the last time you used drugs or alcohol and what were the circumstances:

THERAPY: (Complete if applicable) Attach a Letter From Your Psychiatrist, Psychologist or Therapist and/or Group Facilitator Regarding Your Attendance, Participation and Progress.

Name of Doctor/Therapist: _____ Title: _____

Address: _____ Telephone Number: _____

How often do you attend _____ weekly _____ monthly

Do you attend and participate in group therapy? Yes No Name of the group: _____

How often do you attend the group meetings _____ weekly _____ monthly

How has your participation in individual and/or group counseling benefited you? _____

FITNESS TO PRACTICE IN YOUR LICENSED CAPACITY:

Are you currently under the care of a psychiatrist, physician, dentist, or other healthcare professional? Yes No

If your answer is yes, what is the reason for your treatment: _____

Do you have any physical and/or mental disabilities that would preclude you from performing all duties of a licensed vocational nurse or psychiatric technician? Yes No If your answer is yes, please provide a detailed explanation: _____

Are you currently taking any prescribed and/or over the counter medication? Yes No If your answer is yes, please list all medications and their purpose.

CRIMINAL CONVICTION: (Complete this section if applicable)

Attach Proof of Completion of Probation, Parole or Status of Compliance.

Name of probation/parole officer: _____

Telephone number of probation/parole officer: _____

Date criminal probation was completed or will be completed _____

Are you in compliance with the terms and conditions of your criminal probation? Yes No

Explain fully if you are out of compliance with the terms of your criminal probation _____

ADDITIONAL INFORMATION: List ANY activities which you have used to prevent a reoccurrence of the violation(s) that led to the revocation of your license. (Examples: areas of personal growth, continued education not related to your license, exercise programs, voluntary associations, etc.) *Attach Any Documentation To Support Your Response*

HAVE YOU PREVIOUSLY PETITIONED THE BOARD FOR REINSTATEMENT OF YOUR LICENSE?

Yes No If yes, please provide the attendance dates of the Board Hearings.

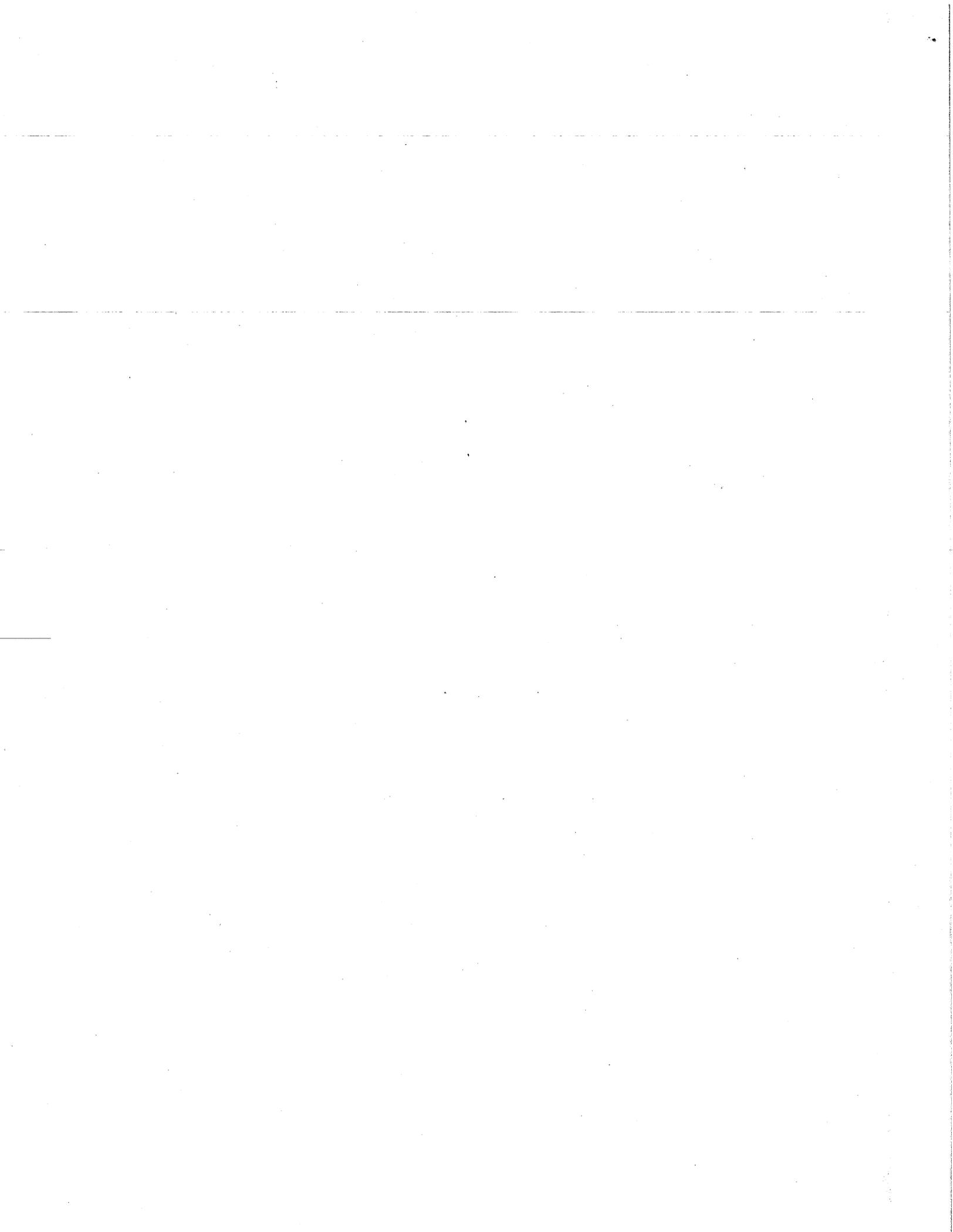
WHY ARE YOU PETITIONING THE BOARD FOR REINSTATEMENT OF YOUR LICENSE?:

WHY SHOULD THE BOARD GRANT YOUR PETITION FOR REINSTATEMENT?:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Your Signature

Date



Agenda Item #24. Attachment E.



BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

Board of Vocational Nursing and Psychiatric Technicians

2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833-2945

Phone 916-263-7800 Fax 916-263-7855 www.bvnpt.ca.gov



Samples of Other Healing Arts Boards' Petition Application Forms:

Board of Chiropractic Examiners

Petition for Reinstatement of License To
Practice Chiropractic Revoked by
Administrative Action

Board of Chiropractic Examiners
 901 P Street, Suite 142A
 Sacramento, CA 95814
 T (916) 263-5355 F (916) 327-0039
 TT/TDD (800) 735-2929
 Consumer Complaint Hotline
 (866) 543-1311
 www.chiro.ca.gov



PETITION FOR REINSTATEMENT OF REVOKED LICENSE

(Revoked through Administrative Disciplinary Action)

Pursuant to Section 10(c) of the Chiropractic Initiative Act no petition for reinstatement of a revoked license will be entertained until two years after the effective date of the Board's disciplinary action.

All items of information in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information will be used to determine qualifications for reinstatement of your chiropractic license.

Board Meeting Date Requested: _____
(see attached sheet for dates)

Please print or type

Name: Last First Middle Former					License number:			
Address: Number Street					Date issued:			
City			State		Zip Code			
Home telephone ()			Work telephone ()			Licensed by: <input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity <input type="checkbox"/> Other _____		
Business Address: Number Street					ATTACH A PHOTOGRAPH Taken Within 60 Days of the Filing of this Application NO POLAROID			
City			State				Zip Code	
Date of Birth	Driver's License Number/State		Social Security Number					

Are you licensed in any other state? Yes No If yes, please specify below.

State/Country	Issue Date	License Number	Current Status

Chiropractic College you attended:

Name of School:		
Dates Attended:	From	To
Graduation Date:		
Date Degree Granted:		

Have you ever been convicted of or pled no contest to a violation of any law of a foreign country, the United States, any state, or a local ordinance? You must include all misdemeanor and felony convictions, regardless of the age of the offense, including those which have been set aside under Penal Code section 1203.4. (Traffic violations of \$300 or less need not be reported.) If yes, include a copy of your criminal court documents, i.e. complaint, minute order, indictment, plea agreement, etc. Yes* No

Are you now on probation or parole for any criminal or administrative violations in this state or any other state? (Attach certified copies of all disciplinary or court documents.) Yes* No

Have you ever had disciplinary action taken against any professional license in this state or any other state? Yes* No

Are you or have you ever been addicted to the use of narcotics or controlled substances? Yes* No

Are you or have you ever been habitually intemperate in the use of alcohol or other drugs? Yes* No

Have you ever been or are you currently under observation or treatment for mental disorders, alcoholism, or drug addiction? Yes* No

* If you answered yes to any of the above questions, you must attach a statement of explanation giving full details.

Answer the Following Questions on an Attached Sheet of Paper

1. List the date of revocation of your license and explain the reason for the disciplinary action.
2. Explain fully why you feel your license should be reinstated.
3. Describe fully your activities and occupation since the date of revocation of your license; include dates, employers and locations.
4. Describe any rehabilitative or corrective measures you have taken since your license revocation to prepare yourself for reinstatement. List dates, nature or programs, and current status. You may include any community service or volunteer work.
5. List all post-graduate or refresher courses, with dates, location and type of course, you have taken since your license was revoked.
6. List all chiropractic literature you have studied during the last year.
7. List all continuing education courses you have completed since your license was revoked. Attach copies of the certificates.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: _____ Signature: _____

Dental Board of California

Reinstatement of a Revoked or Surrendered
License or Modification/Termination of a
Probationary Order



STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
DENTAL BOARD OF CALIFORNIA
 2005 Evergreen Street, Suite 1450, Sacramento, CA. 95815
 T (916) 263-2300 F (916) 263-2347 www.dbc.ca.gov



**IF APPLICABLE, YOUR ATTORNEY'S NAME,
 ADDRESS AND PHONE.**

PETITION OF:	
NAME	_____
ADDRESS	_____ _____ _____
TELEPHONE	_____
CALIFORNIA LICENSE NO.	_____
DATE OF BIRTH	_____

PETITION FOR:

- REINSTATEMENT OF REVOKED OR SURRENDERED LICENSE
- MODIFICATION OF PROBATION
- TERMINATION OF PROBATION

PLEASE TYPE OR PRINT LEGIBLY

EFFECTIVE DATE OF DISCIPLINE	ELAPSED PERIOD TO NOW	DENTAL BACKGROUND
CAUSE FOR DISCIPLINE		A. SPECIALTY, IF ANY BOARD ELIGIBLE <input type="checkbox"/> BOARD CERTIFIED <input type="checkbox"/>
		IF CERTIFIED, YEAR CERTIFIED _____
PERIOD OF PROBATION (IF ANY)		B. CURRENT TYPE OF PRACTICE (Solo, Group, HMO, Govt., etc.)
_____ YEARS	TIME OF PROBATION REMAINING	NAME AND LOCATION OF PRACTICE
	_____ YEARS _____ MONTHS	
ANY PRIOR PETITION HEARINGS IN CALIFORNIA OR IN ANOTHER STATE?		YES <input type="checkbox"/> NO <input type="checkbox"/>
IF YES, GIVE HISTORY IN NARRATIVE STATEMENT INCLUDING DATES OF PRIOR DECISIONS, CAUSES AND PENALTIES.		
ANY PRIOR DISCIPLINE (OTHER THAN THE LATEST) IN CALIFORNIA OR IN ANOTHER STATE?		YES <input type="checkbox"/> NO <input type="checkbox"/>
IF YES, GIVE HISTORY IN NARRATIVE STATEMENT INCLUDING DATES OF PRIOR DECISIONS, CAUSES AND PENALTIES.		

TOTAL YEARS OF DENTAL PRACTICE _____ WHEN FIRST LICENSED IN CALIFORNIA _____ CURRENTLY LICENSED IN OTHER STATES OR COUNTRIES – LIST THEM	EMPLOYMENT HISTORY FOR PAST (5) YEARS NAME & ADDRESS _____ DATES _____
IF NOT PRACTICING DENTISTRY NOW, LIST YOUR CURRENT OCCUPATION, EMPLOYER AND ADDRESS	_____ DATES _____
<p>SINCE THE EFFECTIVE DATE OF YOUR LATEST DISCIPLINARY DECISION, HAVE YOU BEEN INVOLVED IN ANY OF THE FOLLOWING SITUATIONS?</p> NO <input type="checkbox"/> YES <input type="checkbox"/> (A) ON CRIMINAL PROBATION OR PAROLE CURRENTLY?	<p>THE ATTACHED EXHIBITS ARE INCORPORATED AND MADE APART OF THIS PETITION. PLEASE PROVIDE ALL OF THE LISTED EXHIBITS.</p> <p>EXHIBITS</p> A. NARRATIVE STATEMENT B. VERIFIED RECOMMENDATIONS FROM DENTISTS HOLDING CALIFORNIA LICENSES. C. COPY OF THE LATEST DENTAL DISCIPLINARY DECISION AGAINST YOU AND COPIES OF PRIOR DECISIONS IF ANY. D. COPIES OF PRIOR PETITION DECISIONS IF ANY.
NO <input type="checkbox"/> YES <input type="checkbox"/> (B) CHARGED IN ANY PENDING CRIMINAL ACTION?	<p>DECLARATION UNDER PENALTY OF PERJURY</p> <p>I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING, AND ANY ATTACHMENTS, IS TRUE AND CORRECT.</p>
NO <input type="checkbox"/> YES <input type="checkbox"/> (C) CONVICTED OF ANY CRIMINAL OFFENSE? (A CONVICTION INCLUDES A NO CONTEST PLEA. DISREGARD TRAFFIC OFFENCES OF \$100 FINE OR LESS)	DATE _____ PETITIONER SIGNATURE _____
NO <input type="checkbox"/> YES <input type="checkbox"/> (D) CHARGED OR DISCIPLINED BY ANY BOARD?	
NO <input type="checkbox"/> YES <input type="checkbox"/> (E) DISCIPLINED BY ANY HOSPITAL AS TO STAFF PRIVILEGES?	
NO <input type="checkbox"/> YES <input type="checkbox"/> (F) HAD ANY CIVIL MALPRACTICE CLAIMS FILED AGAINST YOU OF \$3,000 OR MORE?	
NO <input type="checkbox"/> YES <input type="checkbox"/> (G) ADDICTED OR HABITUATED TO ALCOHOL OR DRUGS?	
NO <input type="checkbox"/> YES <input type="checkbox"/> (H) HOSPITALIZED FOR ALCOHOL OR DRUG PROBLEMS OR FOR MENTAL ILLNESS?	
IF YOU ANSWER IS YES TO ANY OF THE ABOVE, PLEASE PROVIDE EXPLANATORY DETAILS IN THE ATTACHED NARRATIVE STATEMENT.	

NARRATIVE STATEMENT

[Empty box for narrative statement]

EXHIBIT A

Medical Board of California

Petition for Penalty Relief



MEDICAL BOARD OF CALIFORNIA

Discipline Coordination Unit

2005 Evergreen Street, Suite 1200

Sacramento, CA 95815



PETITION FOR PENALTY RELIEF

INSTRUCTIONS: Please type or print neatly. All blanks must be completed; if not applicable enter N/A. If more space is needed attach additional sheets. Attached to this application should be a "Narrative Statement" and two verified recommendations from a physician and surgeon licensed in any state who has personal knowledge of the reasons for the disciplinary action taken against your license.

I. TYPE OF PETITION (Reference Business and Professions Code sections 2221(b) and 2307)			
<input type="checkbox"/> Reinstatement of Revoked/Surrendered Certificate <input type="checkbox"/> Modification of Probation <input type="checkbox"/> Termination of Probation NOTE: A Petition for Modification and/or Termination of Probation can be filed together. If you are requesting Modification you must specify in your "Narrative Statement" which terms and conditions of your probation you want reduced or modified and provide an explanation. Please check all boxes above that apply.			
II. PERSONAL INFORMATION			
NAME		First	Middle
			Last
HOME ADDRESS		Number & Street	City
			State
			Zip
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	CELL NUMBER	
()	()	()	
CA Physician and Surgeon Certificate Number		Driver's License Number and State of Issuance	
Current or prior medical licenses in other states or countries (please include license number(s), issue date(s), and status of license(s)):			
III. ATTORNEY INFORMATION (If Applicable)			
Will you be represented by an attorney? <input type="checkbox"/> No <input type="checkbox"/> Yes (If "Yes," please provide the following information)			
NAME:			
ADDRESS:			
PHONE:			
IV. DISCIPLINARY INFORMATION			
Provide a brief explanation in your "Narrative Statement" as to the cause for the disciplinary action or the license to be issued on probationary status (e.g., prescribing without prior exam, gross negligence, self-use of drugs, sexual misconduct, conviction of a crime, etc.)			
Do you have any prior or current discipline or license denial in any other state or country? <input type="checkbox"/> No <input type="checkbox"/> Yes (If "Yes," give brief cause for administrative action or license denial in your "Narrative Statement" section, including dates and penalty order (e.g., 5 years' probation.)			

V. MEDICAL BACKGROUND

Total number of years in medical practice:

Medical specialty, if applicable:

Board certified? No Yes If "Yes," year certified:

Current field of medicine: (e.g., GP, OB/GYN, ENT, IM, etc.)

Current type of practice: (e.g., solo, group, HMO, Gov't, etc.)

Name and location of practice:

List hospital memberships:

VI. CURRENT OCCUPATION OTHER THAN PHYSICIAN AND SURGEON (answer only if currently not practicing medicine)

List employer, address, e-mail address, phone number, job title, and duties:

VII. EMPLOYMENT HISTORY (list for the past 5 years only)

Provide the company name, address, phone number, contact person and dates of employment:

Describe any rehabilitative or corrective measures you have taken since your license was revoked, surrendered or placed on probation. List dates, nature of programs or courses, and current status. You may include any community service or volunteer work.

IX. CURRENT COMPLIANCE

Since the effective date of your last Medical Board of California administrative action or if you surrendered your license while under investigation or charges pending, have you:

- 1. Been placed on criminal probation or parole? Yes No
- 2. Been charged in any pending criminal action? Yes No
- 3. Been convicted of any criminal offense? (A conviction includes a no contest plea; disregard traffic offenses with a \$100 fine or less.) Yes No
- 4. Been required to register as a sex offender in any state? (Attach the court order.) Yes No
- 5. Been charged or disciplined by any other medical board? Yes No
- 6. Surrendered your license to any other medical board? Yes No
- 7. Had your staff privileges disciplined by any hospital? Yes No
- 8. Had any civil malpractice claims filed against you? Yes No
- 9. Become addicted to the use of narcotics or controlled substances? Yes No
- 10. Become addicted to or received treatment for the use of alcohol? Yes No
- 11. Been hospitalized for alcohol or drug problems or for mental illness? Yes No

NOTE: If your answer is "Yes" to any of the above questions, please explain in the "Narrative Statement."

X. DECLARATION

Executed on _____ 20 _____, at _____, _____.
(city) (state)

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that all statements and documents attached in support of this petition are true and correct.

Petitioner (print name)

Signature

The information in this document is being requested by the Medical Board (Board) pursuant to Business and Professions Code sections 2221(b) and 2307. In carrying out its licensing or disciplinary responsibilities, the Board requires this information to make a determination on your Petition for Penalty Relief. You have a right to access our records containing non-confidential information as defined in Civil Code section 1798.3. The Custodian of Records is the Licensing Program Manager or Chief of Enforcement at the address shown on the first page.

Physical Therapy Board of California

Petition for Penalty Relief

Reinstatement/Modification/Termination



Physical Therapy Board of California

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY - GOVERNOR EDMUND G. BROWN JR.

Physical Therapy Board of California

2005 Evergreen St. Suite 1350, Sacramento, California 95815

Phone: (916) 561-8200 Fax: (916) 263-2560

Internet: www.ptbc.ca.gov EMAIL: cps@dca.ca.gov



PETITION FOR REDUCTION OF PENALTY

Type of Petition: <input type="checkbox"/> Reinstatement of Revoked License <input type="checkbox"/> Modification of Probation <input type="checkbox"/> Termination of Probation	Location Requested for Hearing: <input type="checkbox"/> Northern California <input type="checkbox"/> Southern California <input type="checkbox"/> First Available Location
Petitioners' Full Name:	If Applicable, Name of Attorney:
Address	Address
City, State, Zip Code	City, State, Zip Code
Home Telephone #:	Telephone:
Business Telephone #:	Fax #:

A. DISCIPLINE INFORMATION

1. Effective Date of Most Recent Discipline		
2. Cause for Discipline:		
3. Effective Date of Probation	4. Period of Probation Order Years: Months:	5. Balance of Probation Remaining Years: Months:
6. List prior Petition Hearings (If Any)		7. List Prior Discipline other than the one listed above.

B. EMPLOYMENT STATUS

1. Are you currently licensed in another state: If yes, include state, year issued and expiration date.	
2. Employment History –List all employers for the last five (5) years, beginning with the most recent employer.	
a. Employer:	Telephone Number:
Address:	Supervisor's Number:
Your Job Title:	Dates of Employment:
Responsibilities:	
Reason for Leaving	
b. Employer:	Telephone Number:
Address:	Supervisor's Number:
Your Job Title:	Dates of Employment:
Responsibilities:	
Reason for Leaving:	
3. Year first licensed in California:	4. Total years of practice:

C. EDUCATION

1. Since the effective date of the decision placing your license on probation, what education course(s), continuing education, or other educational program(s) have you completed? Attach proof of Completion, Attendance, or Transcripts.

Course Title	Name of Provider	Hours/Units	Date Completed

D. RECENT HISTORY:

1. Since the effective date of your latest disciplinary decision, have you:	Yes	No
a. Been placed on criminal probation or parole?		
b. Been charged in any pending criminal action?		
c. Been convicted of any criminal offense?		
d. Been charged or disciplined by any medical society?		
e. Been disciplined by a hospital as to staff privileges?		
f. Been addicted or habituated to alcohol or drugs?		
g. Been hospitalized for alcohol or drug problems or for mental illness?		

If you answered "yes" to any of the above questions, please submit written detailed explanation and attach it to your narrative statement.

E. DECLARATION:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that all statements and documents attached in support of this petition are true and correct.

Date:

Signature:

F. EXHIBITS LIST:

- 1) Petitioner's Narrative Statement
- 2) Two letters of recommendation from California licensed physical therapists with knowledge of petitioners current activities
- 3) Copies of prior disciplinary action(s)
- 4) Copy of completed Live Scan Form