



# **Advisory on Behavior Analysis**

**Virginia Board of Medicine  
June 5, 2017  
10:00 a.m.**

## Advisory Board on Behavior Analysts

Board of Medicine  
Monday, June 5, 2017, 10:00 a.m.  
9960 Mayland Drive, Suite 201  
Richmond, Virginia

Call to Order – Keri Bethune, Ph.D., BCBA-D

Emergency Egress Procedures – Alan Heaberlin

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Roll Call- Denise Mason

Adoption of the Agenda

Approval of Minutes of January 30, 2017

1-3

Public Comment on Agenda Items (15 minutes)

New Business

1. Review of the Application Process

4-16

Announcements

Next Meeting Date: October 4, 2017 @ 10:00 a.m.

Adjournment

**PERIMETER CENTER CONFERENCE CENTER**  
**EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS**  
(Script to be read at the beginning of each meeting.)

**PLEASE LISTEN TO THE FOLLOWING INSTRUCTIONS ABOUT EXITING THESE PREMISES IN THE EVENT OF AN EMERGENCY.**

In the event of a fire or other emergency requiring the evacuation of the building, alarms will sound.

When the alarms sound, leave the room immediately. Follow any instructions given by Security staff

**Board Room 1**

Exit the room using one of the doors at the back of the room. **(Point)** Upon exiting the room, turn **RIGHT**. Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

**Board Room 2**

Exit the room using one of the doors at the back of the room. **(Point)** Upon exiting the room, turn **RIGHT**. Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

You may also exit the room using the side door **(Point)**, turn **Right** out the door and make an immediate **Left**. Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

**Board Rooms 3 and 4**

Exit the room using one of the doors at the back of the room. **(Point)** Upon exiting the room, turn **RIGHT**. Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

**Training Room 1**

Exit the room using one of the doors at the back of the room. **(Point)** Upon exiting the room, turn **LEFT**. Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

---DRAFT UNAPPROVED ---

**ADVISORY BOARD ON BEHAVIOR ANALYSIS**

**Minutes**

**January 30, 2017**

The Advisory Board on Behavior Analysis met on Monday, January 30, 2017 at 10:00 a.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

**MEMBERS PRESENT:** Kate Lewis, MS, BCBA, LBA  
Amanda Kusterer, BCaBA  
Asha Patton Smith, MD  
Gary Fletcher

**MEMBERS ABSENT:** Keri Bethune, PhD, BCBA-D

**STAFF PRESENT:** William L. Harp, M.D., Executive Director  
Alan Heaberlin, Deputy Director, Licensure  
Elaine Yeatts, DHP Senior Policy Analyst  
Denise Mason, Licensing Specialist

**GUESTS PRESENT:** Christy Evanko, VABA

**CALL TO ORDER**

Ms. Lewis called the meeting to order at 10:04 am.

**EMERGENCY EGRESS PROCEDURES**

Dr. Harp announced the Emergency Egress Procedures.

**ROLL CALL**

Roll was called. A quorum was present.

**ADOPTION OF AGENDA**

Ms. Kusterer moved to adopt the agenda as presented. The motion was seconded and carried.

---DRAFT UNAPPROVED ---

**APPROVAL OF MINUTES OF October 3, 2016**

Ms. Lewis made a motion to approve the minutes. The motion was seconded and carried.

**PUBLIC COMMENT**

Ms. Evanko brought several bills that VABA has been tracking in the 2017 Session to the attention of the Advisory Board.

**NEW BUSINESS**

**1. Legislative Update**

Ms. Yeatts reviewed legislation introduced in the 2017 General Assembly that might be of interest to the Advisory Board. No action was required.

**2. HB2095 Registration of Peer Recovery Specialists and Qualified Mental Health Professionals**

Ms. Yeatts discussed with the Advisory Board the accountability of the registration for Peer Recovery Specialists and Qualified Mental Health Professionals registered by the Board of Counseling. Ms. Yeatts stated that a number may have to be "grandfathered."

**3. Amended regulation 18VAC850150-90 to Increase Hours of CE**

Ms. Yeatts discussed with the Advisory Board the draft regulations to increase the continuing education hours required for renewal, reinstatement or reactivation of a license. These new regulations will be published on February 6, 2017 for a public comment period and will become effective on March 8, 2017.

**4. New "Registered Behavior Technician" Credential**

Mr. Heaberlin made the Advisory Board aware that the BACB has received accreditation of its Registered Behavior Technician (RBT) credential by the National Commission for Certifying Agencies (NCCA).

Dr. Harp informed the Advisory Board of the qualifications of a Behavior Technician. The Behavior Technician must be 18 years of age, possess at a minimum a high school diploma or national equivalent, complete 40 hours of training, complete a criminal background check, pass the RBT Competency Assessment, and pass the RBT exam. No further action was required.

**Announcements**

Ms. Mason informed the Advisory Board that there are currently 837 Behavior Analysts and 144 Assistant Behavior Analysts holding licenses with the Virginia Board of Medicine.

---DRAFT UNAPPROVED ---

**Next Meeting Date**

The Advisory Board's next meeting is June 5, 2017 at 10:00 am.

**Adjournment**

The meeting was adjourned at 11:00 a.m.

\_\_\_\_\_  
Kate Lewis, MS, BCBA, LBA, Vice-Chair

\_\_\_\_\_  
William L. Harp, M.D.,  
Executive Director

\_\_\_\_\_  
Denise W. Mason, Licensing Specialist

**INSTRUCTIONS FOR COMPLETING AN APPLICATION TO PRACTICE BEHAVIOR ANALYSIS**

(This form has been designed for you to use as a checklist for processing your application)

**The applicant is responsible for forwarding all of the required forms to the appropriate institutions, states and other agencies.**

\_\_\_ Application Fee – The \$130 application fee is non-refundable.

\_\_\_ Contact the Behavior Analyst Certification Board via email at [verifications@bacb.com](mailto:verifications@bacb.com). Include "Virginia State Verification" in your subject line. BACB will email the verification to the Board of Medicine. Include our address in your request. [medbd@dhp.virginia.gov](mailto:medbd@dhp.virginia.gov).

Request the following information. If all information is not received, your application could be delayed.

- The applicant is currently certified by the BACB as a "Board Certified Behavior Analyst" ("BCBA")
- Date issued \_\_\_\_\_ Expiration Date \_\_\_\_\_
- Certification is currently disciplined? \_\_\_\_\_ If yes, please include dates.
- Certification disciplined in the past? \_\_\_\_\_ If yes, please include dates.

\_\_\_ Employment Activity Questionnaire (Form B). List activities on the chronological page of the application to include postgraduate training and all other activities since graduation from your professional school. Forward Form B (Activity Questionnaire) to those places of professional training/practice/employment listed for the past five years. If engaged in private practice, without affiliations, have another Behavior Analyst submit a letter attesting to your practice. CV'S ARE NOT ACCEPTABLE. Form B must be sent to the Board by the person completing it. The Board will accept this document by mail, fax or via email in a pdf document.

\_\_\_ License Verification or Letter of Good Stand – Verification from all jurisdictions in which you have been issued a full license, certification or registration must be received by the Board. Please contact the applicable licensure board to inquire about processing fees. Verifications may be faxed directly from the jurisdiction. If Virginia is your first license then there will be no license verification to obtain.

Virginia Board of Medicine  
9960 Mayland Drive, Suite 300  
Henrico, VA 23233  
Fax 804-527-4426  
Email – [medbd@dhp.virginia.gov](mailto:medbd@dhp.virginia.gov)

\_\_\_ Experience Verification Form – If Virginia is your first state license and your BACB Experience Verification Forms were completed in Virginia, provide copies of the Experience Verification Form(s) that you provided to the BACB for your certification.

Revised 8/15

\_\_\_ Notification of Certification – If Virginia is your first state license, provide a copy of the letter you received from the BACB or other documentation which notified you of your BACB certification. Copies of certificates are not acceptable.



**INSTRUCTIONS FOR COMPLETING AN APPLICATION TO PRACTICE ASSISTANT  
BEHAVIOR ANALYSIS**

(This form has been designed for you to use as a checklist for processing your application)

**The applicant is responsible for forwarding all of the required forms to the appropriate institutions, states and other agencies.**

\_\_\_ Application Fee – The \$70 application fee is non-refundable.

\_\_\_ Contact the Behavior Analyst Certification Board via email at [verifications@bacb.com](mailto:verifications@bacb.com). Include "Virginia State Verification" in your subject line. BACB will email the verification to the Board of Medicine. Include our address in your request. [medbd@dhp.virginia.gov](mailto:medbd@dhp.virginia.gov).

Request the following information. If all information is not received, your application could be delayed.

- The applicant is currently certified by the BACB as a "Board Certified Behavior Analyst" ("BCBA")
- Date issued \_\_\_\_\_ Expiration Date \_\_\_\_\_
- Certification is currently disciplined? \_\_\_\_\_ If yes, please include dates.
- Certification disciplined in the past? \_\_\_\_\_ If yes, please include dates.

\_\_\_ Employment Activity Questionnaire (Form B). List activities on the chronological page of the application to include postgraduate training and all other activities since graduation from your professional school. Forward Form B (Activity Questionnaire) to those places of professional training/practice/employment listed for the past five years. If engaged in private practice, without affiliations, have another Behavior Analyst submit a letter attesting to your practice. CV'S ARE NOT ACCEPTABLE. Form B must be sent to the Board by the person completing it. The Board will accept this document by mail, fax or via email in a pdf document.

\_\_\_ License Verification or Letter of Good Stand – Verification from all jurisdictions in which you have been issued a full license, certification or registration must be received by the Board. Please contact the applicable licensure board to inquire about processing fees. Verifications may be faxed directly from the jurisdiction. If Virginia is your first license then there will be no license verification to obtain.

Virginia Board of Medicine  
9960 Mayland Drive, Suite 300  
Henrico, VA 23233  
Fax 804-527-4426 Email – [medbd@dhp.virginia.gov](mailto:medbd@dhp.virginia.gov)

\_\_\_ Experience Verification Form – If Virginia is your first state license and your BACB Experience Verification Forms were completed in Virginia, provide copies of the Experience Verification Form(s) that you provided to the BCBA for your certification.

\_\_\_ Notification of Certification – If Virginia is your first state license, provide a copy of the letter you received from the BACB or other documentation which notified you of your BCaBA certification. Copies of certificates are not acceptable.

**PLEASE CHECK APPROPRIATE PROFESSION**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Acupuncturist         | <input type="checkbox"/> Athletic Trainer      | <input type="checkbox"/> BCaBA                   | <input type="checkbox"/> BCBA                              |
| <input type="checkbox"/> Genetic Counselor     | <input type="checkbox"/> Midwife               | <input type="checkbox"/> Occupational Therapist  | <input type="checkbox"/> Occupational Therapist Assistant  |
| <input type="checkbox"/> Physician Assistant   | <input type="checkbox"/> Polysomnographer      | <input type="checkbox"/> Radiologic Technologist | <input type="checkbox"/> Radiologic Technologist - LIMITED |
| <input type="checkbox"/> Radiologist Assistant | <input type="checkbox"/> Respiratory Therapist |  |  |

	<b>Virginia Department of Health Professions</b>
	Board of Medicine
	9960 Mayland Drive, Suite 300 Henrico, Virginia 23233-1463
	Phone: (804) 367-4600 Fax: (804) 527-4426 Email: <a href="mailto:medbd@dhp.virginia.gov">medbd@dhp.virginia.gov</a>

Please provide name and address of organization/individual exactly as it appears on your application chronology

\_\_\_\_\_

Clearly print/type name of applicant

\_\_\_\_\_

Last 4 of Social Security Number: \_\_\_\_\_

The Virginia Board of Medicine, in its consideration of an applicant for licensure, depends on information from persons and institutions regarding the applicant's employment, training, affiliations, and staff privileges. Please complete this form to the best of your ability and return it to the Board by mail, fax or email so the information you provide can be given consideration in the processing of his/her application in a timely manner. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past, and present) and governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Virginia Board of Medicine any information, files or records requested by the Board in connection with the processing of my application.

Signature of Applicant \_\_\_\_\_

1. Date and type of service: This individual served with us as \_\_\_\_\_  
from \_\_\_\_\_ to \_\_\_\_\_  
(Month/Year) (Month/Year)

2. Please evaluate: (Indicate with check mark)

	Poor	Fair	Good	Superior
Professional knowledge				
Clinical judgment				
Relationship with patients				
Ethical/professional conduct				
Interest in work				
Ability to communicate				

3. Recommendation: (please indicate with check mark)

Recommend highly and without reservation       Recommend as qualified and competent

Recommend with some reservation (explain) \_\_\_\_\_

Do not recommend (explain) \_\_\_\_\_

4. Of particular value to us in evaluating any applicant are any notable strengths and weaknesses (including personal demeanor). We would appreciate such comments from you. \_\_\_\_\_

5. The above report is based on: (please indicate with check mark)

Close personal observation       General impression       A composite of evaluations

Other: \_\_\_\_\_

Date (Required): \_\_\_\_\_ Signed by: \_\_\_\_\_

Signator Contact Number: (\_\_\_\_\_) \_\_\_\_\_ Print or type name: \_\_\_\_\_

Title: \_\_\_\_\_

## Virginia DHP

### Initial Applications

#### Application

You have selected to begin an initial application to practice as a Behavior Analyst. If this license type is incorrect, please contact us at (804) 367-4444 for assistance.

#### Application requirements:

- Completion of this online application and payment of the non-refundable application fee
- Verification of certification as a Board Certified Behavior Analyst (BCBA) from the Behavior Analyst Certification Board, Inc. (BACB)
- Verification of practice
- If licensed or certified in any other jurisdiction, verification that there has been no disciplinary action taken or pending in that jurisdiction
- NOTE: In addition to completing this online process applicants may be required to complete additional steps, [CLICK HERE](#) for the full instructions. You will be given another opportunity at the conclusion of the application process to download this form and instructions.

---

#### Instructions for All Applicants:

You will need to complete each of the steps listed on the Initial Application Menu on the left. To begin, please click the Start button below.

Please use the Next and Back buttons at the bottom of each step to navigate through the initial application process. You may click the "Save and finish later" button at any time during the application process. This will allow you to log out of the application, then log back in at a later time without losing any of the information that you have provided.

After completing all of the items in the Initial Application Menu, you will be directed to a brief Workforce Survey, then you will be able to submit your payment.

**Your application will not be forwarded to the Board of Medicine until you have submitted your payment. The Board must then receive all required information relative to your application. Once all information has been received, review will be done in 30 days or less. This entire process usually takes 6-8 weeks if there are no extraordinary aspects to your application. The Board may ask for further information to explain extraordinary aspects, which will lengthen the process. Once payment has been made, fees will not be refunded.**

Start

0 0008

## Virginia DHP

### Initial Applications

#### Application

##### Demographics

#### **INSTRUCTIONS:**

This is the most current information we have on file for you. Please modify any incorrect information that is displayed.

Required fields are denoted with an asterisk (\*).

#### Personal Information

SSN/Virginia DMV #

ex. 123456789:

\*

Date of Birth (mm/dd/yyyy):

\*

Maiden Name (if applicable):

#### **Published Address Information**

*This address is subject to public disclosure under the Freedom of Information Act. You may provide an address other than a residence, such as a Post Office Box or a practice location if you wish.*

Is your current address within the United States?

\*

Address Line 1 (ex. 123 Fourth St.):

\*

Address Line 2 (ex. Apt. 100):

Address Line 3:

City:

\*

State:

\*

Zip Code (ex. 02705 or 027051234):

\*

Phone:

 (xxx-xxx-xxxx)

Email:

0 0000

# Virginia DHP

## Initial Applications

### Application

#### Address of Record

The address information you provide below is your address of record with the Board. Please be advised that all notices from the board, to include renewal notices, licenses, and other legal documents, will be mailed to the address of record provided. This address is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose. Please modify any incorrect information for your mailing address. Required fields are denoted with an asterisk (\*).

Is your current address within the United States?	Yes ▼*
Address Line 1 (ex. 123 Fourth St.):	123 *
Address Line 2 (ex. Apt. 100):	
Address Line 3:	
City:	Richmond *
State:	Maryland ▼*
Zip Code (ex. 02705 or 027051234):	21224 *
Daytime Phone:	804-367-4444 *(xxx-xxx-xxxx)
Other Phone:	(xxx-xxx-xxxx)
Email:	sdf@asldkfj.com *

0 0010

**Virginia DHP**  
*Initial Applications*

Application

BACB Certification

Do you hold current certification as a BCBA® which was obtained by meeting qualifications and passage of the examination required for certification as a BCBA® by the BACB?

Yes ▼\*

BCBA Certification Number:

\_\_\_\_\_\*

Original Certification Date (mm/dd/yyyy):

\_\_\_\_\_\*

Expiration date (mm/dd/yyyy):

\_\_\_\_\_\*

Were your BACB Experience Verifications completed in Virginia?

▼\*

0 0011

**Virginia DHP**  
Initial Applications

Application

Employment Activity

List in chronological order all professional practices since certification. Also list all periods of non-professional activity or employment for more than three months. PLEASE ACCOUNT FOR ALL TIME. If engaged in private practice, list all hospital affiliations. A completed Form B (.PDF file) must be received for all places of professional employment listed for the last five years.

Have you been employed during the last five years?  \*

Beginning Date (mm/dd/yyyy) :	<input type="text"/> *
End Date (mm/dd/yyyy) :	<input type="text"/>
Employer Name:	<input type="text"/> *
Location:	<input type="text"/> *
Position Held:	<input type="text"/> *

To add this record click "**Add**".  
 To edit a record, select the record, make the desired changes and click "**Save**".  
 To delete a record, select the record and click "**Delete**".  
 To clear the form, click "**Clear**".

	Begin Date	End Date	Employment Activity	Location	Position Held
<input type="radio"/>	08/23/1999	08/23/2017	Behavior Analyst	river city	behavior anylyst

0 0012

# Virginia DHP Initial Applications

## Application

### Licensure History

*Verification from all jurisdictions in which you have been issued a full license, certification or registration must be received by the Board. Please contact the applicable jurisdictions to inquire about processing fees. Verifications may be faxed directly from the jurisdiction.*

Have you ever been issued a full license, certification or registration to practice as a Behavior Analyst in any jurisdiction?

Yes  \*

Please enter the jurisdiction, number issued, and status (Active, Inactive, Expired, Suspended or Revoked) of each license.

Jurisdiction:

New Mexico \*

Number Issued:

23 \*

Status:

Revoked  \*

To add this record click "**Add**".  
To edit a record, select the record, make the desired changes and click "**Save**".  
To delete a record, select the record and click "**Delete**".  
To clear the form, click "**Clear**".

	Jurisdiction	Licensure History Number Issued	Status
<input type="radio"/>	North Carolina	23	Revoked

0 0013



# Virginia DHP

## Initial Applications

### Application

#### Licensure Questions

Any supporting documentation related to the questions below should be submitted to the Virginia Board of Medicine at:

Virginia Board of Medicine  
Perimeter Center  
9960 Mayland Drive, Suite 300  
Henrico, VA 23233  
Fax – (804) 527-4426  
Email – medbd@dhp.virginia.gov

- 1. Do you intend to engage in the active practice of your profession in the Commonwealth of Virginia?
  
- 2. Have you ever been denied a license or the privilege of taking a licensure/competency examination by any licensing authority? \*
  
- 3. Have you ever been convicted of a violation of or pled Nolo Contendere to any federal, state, or local statute, regulation or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.) \*
  
- 4. Have you ever been denied clinical privileges or voluntarily surrendered your clinical privileges for any reason? \*
  
- 5. Have you ever been censured or warned or been requested to withdraw or placed on probation, subject to a corrective action plan from any professional school, training program, hospital healthcare facility, healthcare provider, provider network or malpractice insurance carrier? \*
  
- 6. Have you ever been terminated from employment or resigned in lieu of termination from any training program, hospital, healthcare facility, healthcare provider, provider network or malpractice insurance carrier? \*

0 0014

7. Have you ever had any disciplinary actions taken against any of your professional license/certificate/permit/registration related to your professional practice, or are any actions pending?

\*

8. Have you been disciplined by the BACB?

\*

9. Have you ever had any membership in a state or local professional society or certifying board revoked, suspended, or sanctioned?

\*

10. Have you voluntarily withdrawn from any professional society or certifying board while under investigation?

\*

11. Do you have a physical disease, mental disorder, or any condition, which could affect your performance of professional duties?

\*

12. Have you been physically or emotionally dependent upon the use of alcohol/drugs or treated by, consulted with, or been under the care of a professional for any substance abuse within the last two (2) years?

\*

13. Have you been in a health practitioner's monitoring program within the last two (2) years?

\*

14, By entering your initials, you certify that you have carefully read the laws and regulations related to the practice of your profession, which are available at [www.dhp.virginia.gov/medicine/medicine\\_laws\\_regs](http://www.dhp.virginia.gov/medicine/medicine_laws_regs) and you fully understand that funds submitted as part of the application process shall not be refunded.:

\*

**Military Spouse**

Did you relocate with a spouse who is the subject of a military transfer to the Commonwealth of Virginia?

\*

0 0015

**Virginia DHP**  
Initial Applications

Application

Claims History

Have you had any malpractice suits (pending or closed) brought against you in the past ten (10) years?

Yes ▾ \*

Date of Incident (mm/dd/yyyy) :

\*

Verdict /Settlement Amount (if any) :

Narrative description of the clinical care provided :

\*

To add this record click "Add".  
To edit a record, select the record, make the desired changes and click "Save".  
To delete a record, select the record and click "Delete".  
To clear the form, click "Clear".

Incident Date	Amount	Claims History	Claim Description
No data available			

0 0016