



Bureau of Professional Licensing
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BPLHelp@michigan.gov

SPECIAL VOLUNTEER LICENSE APPLICATION

Authority: 1978 PA 368

Print or Type Clearly

Applicant's First Name		Middle Name	Last Name	
U.S. Social Security Number	Date of Birth (MM/DD/YYYY)	10-Digit MI Permanent ID/License Number		Expiration Date of License (MM/DD/YYYY)
Address				
City		State	Zip Code	Country
Telephone Number		Email Address		

List any other name or alias by which you have ever been known, including maiden name, if applicable:

CHECK ONE PROFESSION

- Acupuncturist
- Athletic Trainer
- Audiologist
- Chiropractor
- Dentist
- Dental Specialty – Endodontist
- Dental Specialty – Orthodontist
- Dental Specialty – Pediatric
- Dental Specialty – Periodontist
- Dental Specialty – Prosthodontist
- Dental Specialty – Oral Surgeon
- Registered Dental Assistant
- Registered Dental Hygienist
- Marriage and Family Therapist
- Massage Therapist
- Medical Doctor
- Licensed Practical Nurse
- Registered Nurse
- R.N. Specialty – Nurse Anesthetist
- R.N. Specialty – Nurse Midwife
- R.N. Specialty – Nurse Practitioner
- Nursing Home Administrator
- Occupational Therapist
- Occupational Therapy Assistant
- Optometrist
- Osteopathic Physician
- Pharmacist
- Pharmacy Technician
- Physical Therapist

- Physical Therapy Assistant
 - Physician's Assistant
 - Podiatrist
 - Professional Counselor
 - Master's Limited Psychologist
 - Psychologist
 - Respiratory Therapist
 - Sanitarian
 - Social Service Technician
 - Bachelor's Social Worker
 - Master Social Worker
 - Speech – Language Pathologist
 - Veterinarian
 - Veterinary Technician
 - Controlled Substance License – (coincides with profession)
- Fees: \$ 90.15 (1 Year) 5315-13757
 \$169.70 (2 Years) 5315-23757
 \$249.25 (3 Years) 5315-33757

FOR OFFICE USE ONLY

License Number	Issue Date
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LARA/BPL-VOLLIC (Rev.10/18)

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Continuing Education

Have you been out of practice 3 or more years?	Yes	No
If yes, have you attended at least 2/3 of the required continuing education courses or programs required to renew your license during the 3 years immediately preceding this application?	Yes	No

Good Moral Character Questions

If you answer “yes” to either of the next two questions, you must submit documentation which shows at the current time you have the ability to, and are likely to, serve the public in a fair, honest, and open manner, that you are rehabilitated, or that the substance of the former offense is not reasonably related to the occupation or profession for which you are seeking a license. Documentation may include a certificate of employability, if applicable.

Have you ever been convicted of a felony?	Yes	No
Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of two years or a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance?	Yes	No

License(s) in Other State(s) and/or Country

List each state or country where you have ever held a health profession license, the license number, the date issued, how the license was obtained, and whether sanctions have ever been imposed against that license or registration.
(Attach additional sheets if necessary)

If you indicate there have been sanctions imposed against a license or registration, you must disclose the applicable state(s) and/or country. Submit documentation that the sanction in the other state(s) and/or country is not permanent, that it was not the result of a patient safety violation, and if you were required by the state(s) and/or country that imposed the sanction to participate in and complete a probationary period, a treatment plan as a condition of the continuation of your licensure that it was completed or you did not complete the probationary period or treatment plan because you ceased engaging in the practice of medicine in that state(s) and/or country.

State/Country	Permanent License/Registration Number	Date of Issuance	How Obtained (Examination/Endorsement)	Have You Ever Had Sanctions Imposed Against this License/Registration?

Required Additional Documents:

All Applicants

- There is no fee for the special volunteer license. However, there is a fee for a controlled substance license, if the applicant is authorized to hold a controlled substance license and needs it to provide services with the special volunteer license.
- If you have been out of practice for 3 years or more and you were licensed in a profession with continuing education requirements for renewal, you must submit proof of completing 2/3 of the required continuing education courses completed during the 3 years immediately preceding this application. Information regarding continuing education may be found at www.michigan.gov/healthlicense and click on your specific profession, then under “Licensing Information” click on “CE Requirements”.
- An individual is considered retired from engaging in the practice of a health profession if the individual's license has expired with the individual's intention of ceasing to engage, for remuneration, in the practice of the health profession.

CERTIFICATION AND SIGNATURE

I confirm that I have retired from engaging in active practice of a health profession and that I am now applying for a special volunteer license. This license will be utilized to donate my expertise for the health care and treatment of indigent and needy individuals in this state or for the health care and treatment of individuals in medically underserved areas of this state.

I understand that I will be subject to all the provisions of the Public Health Code regarding licensure including continuing education requirements and disciplinary action if I am granted a special volunteer license.

I affirm that I will not receive any payment or compensation, either direct or indirect, or have the expectation of any payment or compensation for any health care and treatment services provided by me under the special volunteer license and I will not engage in activities outside the scope of practice of the profession for which I was licensed prior to retirement.

I certify that the statements in this application are true and complete. I understand that any omitted statement, misrepresentation, or fraud may be cause for denial of my application, disciplinary action, or may be punishable by law. Further, by signing below, I certify that I have completed the required number of continuing education credits.

Signature of Licensee

Date

Printed Name of Licensee