Virginia Birth-Related Neurological Injury Compensation Program
2010 Exemption Form Affidavit

This Affidavit should be completed only by physicians who claim an exemption from the assessment in Va. Code § 38.2-5020.

State of residence _____City/County of residence_____

I, _____, certify that on, September 30, 2009, I was the holder of a valid medical license issued by the Commonwealth of Virginia and, under oath, do hereby swear and affirm that I am a physician:

(Check only the boxes that apply)

1. ❑ who is employed by the Commonwealth of Virginia or the federal government and whose income from professional fees is less than 10% of my annual salary (you must be directly employed by the state or federal government).

2. ❑ who is enrolled in a full-time graduate medical education program accredited by the American Council for Graduate Medical Education.

   Place of Medical Residency _____.

3. ❑ who has retired from active clinical practice

4. ❑ whose active clinical practice is limited to the provision of services, voluntarily and without compensation, to any patient of any clinic organized in whole or in part for the delivery of health care services without charge.

5. ❑ who does not practice medicine in Virginia.

I understand that this statement is given under oath for the purpose of obtaining an exemption from the payment to the Birth-Related Injury Fund of a $300 assessment required by Va. Code § 38.2-5020 to be paid by all licensed physicians in Virginia who are not Participating Physicians. This Affidavit will be filed with the Virginia Birth-Related Injury Program to obtain the claimed exemption.

_____ _____
Physician Signature Date

_____ _____
Physician Printed Name VA Medical License Number (10 digits)

_____ _____
Current Address Telephone Number (with area code)

_____ _____
City, State, Zip Code E-Mail