State of West Virginia
West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, WV 25311
Telephone (304) 558-2921
Fax (304) 558-2084

PHYSICIAN ASSISTANT LICENSURE REQUIREMENTS FOR THE STATE OF WEST VIRGINIA

All applicants for physician assistant licensure in the State of West Virginia shall provide evidence of the following:

1. Proof of graduation from an approved program of instruction in primary health care or surgery.

2. Successful completion of the National Certification Examination for Primary Care Physician Assistants and evidence of current certification.

3. Good Moral Character.

4. Proof of attained baccalaureate or master's degree, as evidenced by a copy of the diploma.

We do accept information from the Federation Credentials Verification Service (FCVS).

There are no exceptions to the above requirements, except at the discretion of the Board, a physician assistant may be licensed if he or she meets either of the following standards:

1. He or she is a graduate of an approved program of instruction in primary health care or surgery prior to July 1, 1994, and has passed the certifying examination for a physician assistant administered by the National Commission on Certification of Physician Assistants (NCCPA) and has maintained certification by that commission so as to be currently certified; **or**
2. He or she had been certified by the board as a physician assistant then classified as “Type B”, prior to July 1, 1983.

Inquiries regarding these requirements may be made to the staff of the West Virginia Board of Medicine or additional information may be obtained from the Board’s website at www.wvbom.wv.gov. Additional copies of the Physician Assistant law and the Board of Medicine Rules may be obtained from the Board upon request or are available on the website.

All licenses expire March 31 every odd numbered year. If renewal is not received by this date, this license will be cancelled or suspended. Licenses are not backdated under any circumstance.

INSTRUCTIONS FOR COMPLETING APPLICATION FOR PHYSICIAN ASSISTANT LICENSURE

Page 1: Complete in full with recent photograph attached. The name you enter must exactly match the name on your diploma, or documentation of formal name change must be submitted.

Page 2&3: Answer all questions. False answers to these questions may result in licensure denial or revocation.

Page 4: Complete in full and return with the application. List all states in which you are now or have ever been certified or licensed as a physician assistant, regardless of the status of that license. List all employment since graduation from physician assistant school. False answers may result in licensure denial or revocation.

Page 5: Complete in full and return with the application.

Page 6: Complete this page in the presence of a Notary Public and return it with the application. The applicant's oath on this page applies to all statements on any and all pages of the application.

Page 7: Must be signed and dated by you and your supervising physician(s).

Page 8: Certification: This must be signed by the physician assistant and supervising physician(s).

Page 9: You must send this page to your college for completion. The school is to return it directly to the WV Board of Medicine.

Page 10: This page is to be completed by a medical doctor (not a D.O.) who is licensed in the United States. The Affiant must have known you for a minimum of two (2) years and must not be related to you by blood or marriage. The form must be notarized. **This is not to be completed by the applicant and cannot be completed by the proposed supervising physician.**

Page 11: This page is to be sent to each state and jurisdiction where you now hold or have ever held certification or licensure as a physician assistant, regardless of the status of that license. Please complete only the top section of this page. The state licensing Board will complete the rest of the information. You may make copies of this page as needed.

If you are requesting more than three (3) supervising physicians, please copy pages 2, 3 and 4, furnish the required information and attach to this application.

THE FOLLOWING MUST BE SUBMITTED WITH THIS APPLICATION:

1. For duties and procedures in addition to those listed on the attached basic job description (page 7), a **concise** list of those duties and procedures must be attached and in the same format as the basic job description. This additional job description must be signed and dated by the physician assistant and supervising physician(s). The original copy must be submitted with this application and will be presented to the Board for consideration and approval. (See next page.)
2. **CASHIER'S CHECK OR MONEY ORDER** in the amount of $250.00, payable to the WV Board of Medicine. **No personal checks will be accepted. This fee is non-refundable.** If the fee is not submitted in the correct form, your application will not be processed and will be returned to you in its entirety.
3. Copy of your physician assistant diploma.
4. Documentation of your current certification status from the National Commission on Certification of Physician Assistants (NCCPA) or proof of registration for the next scheduled examination date.
5. **National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB):** This is an additional requirement to complete your application. Please contact the NPDB/HIPDB at 1-800-767-6732 to request the "Practitioner Request for Information Disclosure" self-query forms. You may find these forms on their website at www.npdb-hipdb.hrsa.gov. Once you receive the forms, complete them in their entirety, sign in the presence of a notary, and forward to the NPDB/HIPDB. The NPDB/HIPDB will generate two reports (one for each data bank) and return those reports to you. You **MUST** submit the **ORIGINAL** reports (not photocopies) to this office.

ADDITIONAL INSTRUCTIONS

Proposed additional job description shall consist of the following:

l. Physician Assistant's name.
2. Supervising Physician(s)'s name(s).
3. A **concise** list of duties and procedures to be performed by the Physician Assistant. This additional job description will be presented to the Board for consideration and approval. Also, the Board **may** require documentation of experience and qualifications, and an accompanying letter attesting to the Physician Assistant's said qualifications to perform such duties and procedures by the supervising physician(s).
4. The typed names **and** signatures of both the Physician Assistant and supervising physician(s). This office must receive the ***ORIGINAL JOB DESCRIPTION*** bearing ***ORIGINAL SIGNATURES*** of the supervising physician(s) and Physician Assistant. No photocopies or fax copies will be accepted.

The Board of Medicine recognizes that a Physician Assistant may be employed by a partnership, group practice, or within an institution or hospital setting rather than directly by the supervising physician. However, it is imperative that any designated supervising physician be an active participant in the required supervision of the Physician Assistant.

BOARD MEETINGS:

Board meetings are held every other month, beginning in January. When your application is processed, you will receive a letter notifying you of what documentation is outstanding. When all documentation has been received, you will be mailed information to schedule your interview. Your application **MUST** be complete (which includes all supporting documentation), **BEFORE** you may schedule your interview with a Board Member. This interview must be completed **at least** fifteen (15) business days before the next scheduled Board meeting for your name to be placed on the Board's agenda for consideration. However, if you answer "yes" to any Personal Data question on Page (2) of the application, you may be required to appear before the Physician Assistant Committee and you may not be eligible for any type of temporary license.

TEMPORARY APPROVAL:

After completion of a satisfactory interview, your application will be reviewed by this office and upon completion of this review, you may request a temporary license. This request must be accompanied by a $50.00 temporary license fee.

NOTICE

In order to comply with federal law, the West Virginia Board of Medicine is obligated to inform each applicant or licensee from whom it requests a Social Security Number that disclosing such number is MANDATORY in order for this Board to comply with the requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. If this Board should be required to make a report about one of its applicants or licensees to either of these data banks, it must report that individual's Social Security Number.

AT THE INTERVIEW, YOU MUST PRESENT THE FOLLOWING:

1. The original interview form which will be mailed to you from this office upon completion of your application.

2. Your original Physician Assistant diploma.

3. Documentation of current certification status

   OR

   Documentation of application to the NCCPA for sitting for the next offered Certifying Examination.

Once you are approved for initial licensure by this Board, you may apply for:

1. Change of Supervisor at Same Job Location
2. Change of Job Location with Same Supervisor
3. Change of Job Location and Supervisor
4. Additional Job Location and Supervisor
5. Additional Job Location with Same Supervisor

You must request an application from this office to make any of the above changes and/or additions. Along with the application, you must submit a new job description signed by both you and your supervising physician(s), and the $50.00 fee. You **MAY NOT** begin working under the requested change(s) and/or addition(s) until you have received written notice stating that approval has been granted from the Board office.

PRESCRIPTIVE WRITING PRIVILEGES INFORMATION:

Only after you have been licensed by this Board will you be eligible to apply for prescriptive writing privileges. You must meet the following conditions to obtain prescriptive writing privileges:

1. The physician assistant has performed patient care services for a minimum of two (2) years immediately preceding the submission of an application requesting limited prescriptive privileges: Provided, that to meet this condition, the first year of patient care may be as a student in an approved physician assistant program;

2. The physician assistant has successfully completed an accredited course of instruction in clinical pharmacology approved by the Board of not less than four (4) semester hours;

3. Board approval of a formulary which includes the categories of drugs the physician assistant would be prescribing at the direction of his or her supervising physician;

4. The physician assistant continues to maintain national certification as a physician assistant.

WEST VIRGINIA BOARD OF MEDICINE

101 DEE DRIVE, SUITE 103, CHARLESTON, WEST VIRGINIA 25311, (304) 558-2921, ext. 210

OFFICE USE ONLY

Int._____

Date_____/_____/_____

TMP_____

Issued_____/_____/_____

Perm._____

Issued:_____/_____/_____

APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

Please type or print clearly. Do not leave any sections blank. If not applicable, write N/A.

Applicant's Name: _____
(Last) (First) (Middle) (Suffix)

Alternate Name (including maiden name):_____
(Last) (First) (Middle) (Suffix)

Email address:_____ Social Security Number:_____-_____-_____

Date of Birth:_____/_____/_____ Place of Birth:_____
(MM) (DD) (YY)

Mailing Address:_____ Phone:(_____)_____-_____
(Business Name) (Street or Post Office Box)

City:_____County:_____ State:_____ Zip:_____

Home Address:_____ Phone:(_____)_____-_____
(Street or Post Office Box)

City:_____County:_____ State:_____ Zip:_____

Name and Address of Physician Assistant School:_____

_____Date of Graduation:_____/_____/_____
(MM/) (DD) (YY)

Are you certified by the National Commission on the Certification of Physician Assistants (NCCPA)? Yes_____ No_____

If yes, Certificate No.:_____ Expiration Date:_____/_____/_____
(MM) (DD) (YY)

INSTRUCTIONS: Photographs must be of studio quality with head and shoulder areas only, with features distinct. Photographs must have been taken within the last 12 months.

PHOTO AREA

Paste photograph in this area.
Photo may be smaller, but not larger, than this box.
Complete and sign the affidavit to the right.

Proof photos, negatives, copies of photographs, poor quality digital photos, photographs cut from books or newspaper articles are NOT accepted.

PHOTO DECLARATION

I hereby declare under penalty of perjury under the laws of the State of West Virginia, that the photo of myself attached hereto, was taken on or about

_____ (Date)

Sex (circle one): M or F

color of hair _____

color of eyes _____

height _____ft. _____in. weight _____lbs.

identifying marks:_____

_____
Signature of Applicant:

APPLICATION CERTIFICATION

I hereby certify that I have read the instructions (pages i through iv) explaining the licensure requirements for the State of West Virginia, and I understand what I have read and what I am required to produce for licensure in the State of West Virginia. I understand that if I am unable to meet all these requirements, including the production of all required documents and materials, I must be denied licensure in the State of West Virginia. I hereby certify that I am able to meet all these requirements for licensure in the State of West Virginia and that I will be able to produce all required documents and materials and that I will make no request of the Board for a waiver of any of the requirements, including the production of all required documents and materials. I understand that if I make any request for such a waiver, my request must and will be denied.

I also understand that if this application is not completed within six (6) months, I will be required to update the application fully.

Physician Assistant's Signature:_____ Date:_____

AUTHORIZATION FOR RELEASE OF APPLICATION STATUS

The person(s) listed below have my permission to check on the status of my application for a West Virginia license. I understand that I may revoke this authorization, in writing, at any time during the application process.

_____ _____

Type or print name clearly Type or print name clearly

Physician Assistant's Signature:_____ Date:_____

Answers to the following questions now are required under the provisions of West Virginia Code §48-15-303. Also, West Virginia Code §48-15-303 requires this application to state that "making a false statement may subject the license holder to disciplinary action including, but not limited to, immediate revocation or suspension of the license."

I certify, under penalty of false swearing, that:	YES	NO
1. I have a court ordered child support obligation	_____	_____
2. I have a court ordered child support obligation and any arrearage amount equals or exceeds the amount of child support payable for six (6) months..	_____	_____
3. I am the subject of a child support related subpoena or warrant	_____	_____

Physician Assistant's Signature:_____ Date:_____

FALSE OR FRAUDULENT ANSWERS TO THE FOLLOWING QUESTIONS MAY RESULT IN LICENSURE DENIAL OR REVOCATION

Have you, in any jurisdiction, for any reason:

		YES	NO
1.	been called before or appeared before any board or panel for discussions or questions concerning violations of the law or rules pertaining to your practice as a physician assistant, or for unethical conduct?……..	_____	_____
2.	†been charged with or convicted of or pled nolo contendere to any felony or misdemeanor?……..	_____	_____
3.	†been charged with or convicted of a violation of the Controlled Substance Act or any other federal, state or local law pertaining to the manufacture, distribution, prescribing, or dispensing of controlled substances?……..	_____	_____
4.	had limitations, restrictions or conditions placed upon your certificate or license to practice, or had your certificate or license to practice suspended, revoked or subjected to any kind of disciplinary action, including censure, reprimand or probation, and/or are any disciplinary actions pending against you?.....	_____	_____
5.	voluntarily surrendered or limited your certificate or license to practice?……..	_____	_____
6.	††had any hospital privileges limited, restricted, suspended, revoked, or subjected to any kind of disciplinary action, including censure, reprimand or probation?…….	_____	_____
7.	voluntarily resigned from any medical staff or voluntarily limited such staff privileges while under investigation by any health care institution or committee thereof or prior to any final decision by a hospital or health care facility's governing board?…….	_____	_____
8.	been denied the right to take an examination for certification or licensure in any state, or been ejected from any physician assistant examination?…….	_____	_____
9.	been denied certification or licensure to practice as a physician assistant?……..	_____	_____
10.	had your DEA registration restricted or removed?……..	_____	_____
11.	been convicted of Medicare or Medicaid fraud, and/or received any sanctions, including restriction, suspension or removal from practice imposed by an agency of the federal or state government?…….	_____	_____
12.	*had any judgements or settlements arising from professional liability rendered or made against you, and if so, how many? _____……	_____	_____
13.	failed the NCCPA examination or not maintained certification at any time?…….	_____	_____
14.	**been addicted to, or received treatment for the use or misuse of, prescription drugs and/or illegal chemical substances, or been dependent upon alcohol or received treatment for alcohol dependency?…….	_____	_____
15.	had any interruption in your practice which might reasonably be expected by an objective person to currently impair your ability to carry out the duties and responsibilities of the medical profession in a manner consistent with standards of conduct for the medical profession?……..	_____	_____
16.	had anything occur which might reasonably be expected by an objective person to currently impair your ability to carry out the duties and responsibilities of the medical profession in a manner consistent with the standards of conduct for the medical profession?…….	_____	_____

PHYSICIAN ASSISTANT'S SIGNATURE: _____DATE:_____

IMPORTANT INFORMATION

If you answered "YES" to ANY of the above questions, you MUST furnish full details on an 8 1/2 x 11 sheet of paper which MUST be attached to this application.

†If you answered "YES" to Question 2 and/or 3, you MUST cause to be submitted directly to this office from the court all documents pertaining to your answer.

††If you answered "YES" to Question 6, you MUST cause to be submitted directly to this office from the facility all information pertaining to your answer.

*If you answered "YES" to Question 12, you MUST furnish full details on an 8 1/2 x 11 sheet of paper which MUST be attached to this application. For each judgement or settlement you MUST furnish the names of the claimant and your insurer, the amount and date of the judgement or settlement, and specify whether it is a judgement or settlement. It is your responsibility to contact your insurance carrier if you are uncertain as to whether any claim has been settled.

**If you answered "YES" to Question 14, and have gone through a rehabilitation program, you MUST have that program furnish this Board a report of your treatment and progress.

STATE LICENSURE INFORMATION

List all licenses held in other states or jurisdictions regardless of the status of that license (i.e., active, inactive, lapsed, expired, revoked, suspended, or surrendered) and list any state or jurisdiction in which you have ever applied for a physician assistant license, including those where your application was withdrawn.

I have applied for licensure in the following states:	Year	Granted		Permanent or Temporary	License Number	Status (See list above)
		Yes	No			

PROFESSIONAL ACTIVITIES

List in chronological order all of your professional activities and/or places of employment since graduation from physician assistant school. This includes hospitals, teaching institutions, HMO's, private practice, corporations, military assignments, government agencies, and locum tenens assignments. Also, include all periods of unemployment. List all employment outside of your practice as a physician assistant since graduation from physician assistant school in the separate section at the bottom of this page. You may attach additional sheets if needed. C.V. not accepted in lieu of completion of this page.

From MM/DD/YY	To MM/DD/YY	Employer Name	Employer Address	Position

EMPLOYMENT OUTSIDE OF PRACTICE AS A PHYSICIAN ASSISTANT

From	To	Employer Name	Employer Address	Position

If you need additional space, attach an 8½ x 11 sheet of paper. On attachment, please include your name and the page number of the application. Provide complete information. Otherwise, requesting additional information from you may lengthen the application process.

Date you are expected to begin work:_____ (You **MAY NOT** begin working as a physician assistant without **written** approval from the West Virginia Board of Medicine.)

PROPOSED EMPLOYMENT INFORMATION

Supervising physicians:

Type of job location (i.e., clinic, hospital, satellite clinic, physician's office):

1. _____, M.D.

   Job Locations (list physical address):

   1. _____ _____
      _____ Phone number: (_____)_____-_____
   2. _____ _____
      _____ Phone number: (_____)_____-_____
   3. _____ _____
      _____ Phone number: (_____)_____-_____

2. _____, M.D.

   Job Locations (list physical address):

   1. _____ _____
      _____ Phone number: (_____)_____-_____
   2. _____ _____
      _____ Phone number: (_____)_____-_____
   3. _____ _____
      _____ Phone number: (_____)_____-_____

3. _____, M.D.

   Job Locations (list physical address):

   1. _____ _____
      _____ Phone number: (_____)_____-_____
   2. _____ _____
      _____ Phone number: (_____)_____-_____
   3. _____ _____
      _____ Phone number: (_____)_____-_____

Name & Address of Employer: _____

_____

SIGNATURE OF APPLICANT:_____DATE:_____/_____/_____

AFFIDAVIT

I, _____, being first duly sworn, depose and say that I am the person described and identified; that I am of good moral character; that I have not engaged in any of the acts prohibited by the statutes of the State of West Virginia; that I am the person named in the diploma which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby request and authorize all hospitals, medical institutions or organizations, personal references, physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the West Virginia Board of Medicine any information, files, or records required by the Board regarding my clinical ability, education, training, professional ethics, character, physical and mental health, emotional stability, veracity, and any other factors which will or may reflect upon my competence, ethical integrity or physical or mental well-being, for its evaluation of my professional qualifications for licensure in the State of West Virginia. I hereby release all such individuals and entities and their employees, agents and designees from any and all liability for the transmittal of any information or records bearing on my professional qualifications in connection with this request and authorization.

I have carefully read and understood all the questions included on each page of this application and have answered all of the questions completely, without reservations of any kind. I declare that my answers and all statements made by me herein are true and correct. I understand that any license issued based upon this application is based on the truth of the statements contained in this application. Should I furnish any false information in this application, I hereby agree and understand that such act shall constitute good cause for the denial, suspension, or revocation of my license to practice as a physician assistant in the State of West Virginia.

A photocopy of this Affidavit shall have the same force and effect as the original.

_____
Applicant's Signature

Subscribed and sworn to before me this _____ day of _____, _____.
(Month) (Year)

NOTARY SEAL

_____
Signature of Notary Public

_____
Name of State

My commission expires _____/_____/_____.
(MM) (DD) (YYYY)

PHYSICIAN ASSISTANT JOB DESCRIPTION

MEDICAL RESPONSIBILITIES:

1. Screen patients to determine the need for medical attention;
2. Review patient records to determine health status;
3. Take a patient history;
4. Perform a physical examination;
5. Perform development screening examinations on children;
6. Record pertinent patient data;
7. Make decisions regarding data gathering and appropriate management and treatment of patients being seen for the initial evaluation of a problem or the follow-up evaluation of a previously diagnosed and stabilized condition;
8. Prepare patient summaries;
9. Initiate requests for commonly performed initial laboratory studies;
10. Collect specimens for and carry out commonly performed blood, urine and stool analyses and cultures;
11. Identify normal and abnormal findings in history, physical examination and commonly performed laboratory studies;
12. Initiate appropriate evaluation and emergency management for emergency situations; for example, cardiac arrest, respiratory distress, injuries, burns and hemorrhage;
13. Perform clinical procedures such as:
    a. Venipuncture;
    b. Electrocardiogram;
    c. Care and suturing of minor lacerations;
    d. Casting and splinting;
    e. Control of external hemorrhage;
    f. Application of dressings and bandages;
    g. Removal of superficial foreign bodies;
    h. Cardiopulmonary resuscitation;
    i. Audiometry screening;
    j. Visual screening; and
    k. Carry out aseptic and isolation techniques;
14. Provide counseling and instruction regarding common patient problems; and
15. Execute documents at the direction of and for the supervising physician.
16. Prepare patient discharge summaries if physician assistant has been directly involved in patient care.
17. Assist in Surgery.
18. May assist the physician under direct supervision in a manner by which to learn and become proficient in new procedures.

_____ _____

Physician Assistant Signature Date

_____

Supervising Physician Signature Date Print or Type Name WV License No.

_____

Supervising Physician Signature Date Print or Type Name WV License No.

_____

Supervising Physician Signature Date Print or Type Name WV License No.

CERTIFICATION

We have each reviewed a current copy of the West Virginia Medical Practice Act and Legislative Rules governing the extent to which physician assistants may function in this State. We have read and understand them. We agree that we will abide by the West Virginia Medical Practice Act and Legislative Rules and any which may from time to time be enacted by the West Virginia Board of Medicine.

_____ _____
Signature of Physician Assistant Date

_____ _____
Signature of Supervising Physician Date

_____ _____
Signature of Supervising Physician Date

_____ _____
Signature of Supervising Physician Date

PHYSICIAN ASSISTANT EDUCATION VERIFICATION

This section to be completed by the applicant.
In applying for a license to practice as a physician assistant, the West Virginia Board of Medicine requires this form to be completed by the school wherein I received my physician assistant degree. This is your authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the West Virginia Board of Medicine, 101 Dee Drive, Suite 103, Charleston, West Virginia 25311. Your prompt response will be appreciated.

Name:_____ DOB:_____/_____/_____

Name as issued on diploma, if different from above:_____

Date of Graduation: _____/_____/_____ SSN:_____-_____-_____

Address:_____
P.O. Box or Street Address City State Zip

Signature:_____ Date:_____/_____/_____

CERTIFICATE OF DEAN, SECRETARY, OR REGISTRAR OF COLLEGE

(This form must be completed by a representative of the College)

This is to certify that _____
(Name of Graduate)

has satisfactorily completed _____ years of physician assistant education at the

_____, located at
Name of Physician Assistant College

_____.
Mailing Address City State Zip or Postal Code Country

The aforesaid graduate received the degree of _____ from

this institution on _____/_____/_____.
Month Day Year

INSTITUTIONAL SEAL

Signature:_____

Title:_____

Date of Signature:_____/_____/_____
Month Day Year

GOOD MORAL CHARACTER STATEMENT

State of_____

County of_____

I, _____, M.D., am currently licensed in the
(Name of Affiant) (See Instructions, Page ii)

State of _____ and I swear that I have known the

applicant _____ well for a minimum of two (2) years.
(Name of applicant goes here)

Further, I know him/her to be a person of good moral character, and he/she is physically and mentally capable of practicing as a Physician Assistant.

_____
Signature of Affiant

_____
Print Name

_____
Address of Affiant

_____
City State Zip

Sworn to before me this _____day of _____, _____.
(Month) (Year)

My commission expires _____/_____/_____.
Month Day Year

NOTARY SEAL

_____
Signature of Notary Public

Return this form to:

WEST VIRGINIA BOARD OF MEDICINE
101 DEE DRIVE, SUITE 103
CHARLESTON, WEST VIRGINIA 25311

VERIFICATION OF LICENSURE

THIS SECTION TO BE COMPLETED BY APPLICANT:

I, _____, hereby authorize and request the State Board of _____ , having control of any documents, records, and other information pertaining to me, to furnish to the **WEST VIRGINIA BOARD OF MEDICINE** information including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent information.

_____ _____
Signature License Number Issue Date

_____ _____
Name in Full (Please Print) Date of Birth Social Security No.

_____ _____
Other Names Used in Obtaining Licensure Current Address

This section is to be completed by an official of the state board and returned to the **WEST VIRGINIA BOARD OF MEDICINE, 101 DEE DRIVE, SUITE 103, CHARLESTON, WV 25311**.

STATE OF:_____

FULL NAME OF LICENSEE:_____

GRADUATE OF:_____

LICENSE NO.:_____ ISSUE DATE:_____/_____/_____ EXPIRATION DATE:_____/_____/_____

CURRENT STATUS:_____

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?
YES_____ NO_____ UNABLE TO DIVULGE_____ (**If yes, please attach details**)

Have formal disciplinary proceedings ever been initiated against applicant or applicant's license by a disciplinary authority in your state? YES_____ NO_____ UNABLE TO DIVULGE_____ (**If yes, please attach details**)

Has the applicant ever had his or her certificate or license to practice as a physician assistant limited, conditioned, restricted, suspended, or revoked or subjected to any kind of disciplinary action, including censure, reprimand or probation, or has the applicant every voluntarily surrendered or limited his/her license to practice as a physician assistant, in your state?
YES_____ NO_____ UNABLE TO DIVULGE_____ (**If yes, please attach details**)

COMMENTS:_____

_____

SIGNED_____

BOARD SEAL

TITLE_____

DATE_____