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

Dear Applicant:

We thank you for your interest in obtaining a medical license in the State of West Virginia. It is our goal to see that you receive your license in the shortest time possible with as little inconvenience as possible. If you follow the steps outlined below, you will assist in expediting the processing of your application:

1. *Complete the application as soon as possible* – The application process will not begin until the Board receives the portion of the application that is to be completed by you, which must be accompanied by the correct fee. Be aware that completion of the licensure process generally occurs within three to six months from the date your application is received in this office.
2. *Be complete* – We receive information from more than one source. As a result, it is crucial for you to provide complete information. Omissions or discrepancies will delay the process. Send all information and documentation requested. Initial and date each correction you make. Information received in this office from third parties or from your answers to the questions may require clarification or submission of additional materials.
3. *Follow the directions* – Do not substitute a different document for the one requested by the Board. Read the application in its entirety before you begin completing it.
4. *Request verifications from third parties immediately upon receipt of the application* – You should contact those agencies directly to inquire as to the procedure and fee for requesting the information needed by the Board. Send a cover letter with the request form asking the party who will complete the form to assure that all questions are answered and appropriate signatures and seals are affixed. We suggest you follow your written requests within two weeks with a phone call to the third party to ensure forms were sent to this office. We do accept information from the Federation Credentials Verification Service (FCVS).
5. *Fees* – The permanent license fee is $400. **Only** Cashier's Checks or Money Orders payable to the West Virginia Board of Medicine will be accepted. We do not accept personal checks. 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. Fees are not refundable under any circumstance.
6. *Telephone queries about status of applications* – Unnecessary calls to our office will delay processing time as this takes time away from processing applications. We are required to restrict our response about the status of an application to the applicant or the applicant's attorney, unless you have completed and signed the Authorization for Release of Application Status on Page 2 of the application. Within thirty days of receipt of your application in this office, you should receive a letter notifying you of the status of your application. If you are concerned about your application being received in this office, please mail it Certified – Return Receipt or use overnight mail.
7. *Tips, Tricks, Hints of the Trade* – Certain techniques expedite rapid third-party responses. Provide third parties with self-addressed, stamped postcards to be returned to you when documentation is sent to the Board office. Provide third parties with overnight mail envelopes so that the documentation may be forwarded to the Board in a timely manner. For your own records, note the dates of each request sent to third-party agencies.

8. *Save Time, Save Money, Reduce Anxiety* – **Do not make commitments on loans, practice start dates, home purchases, airline tickets, etc., until a license is granted.** It may be that not all physicians who apply will receive a license. Don't waste valuable time assuming that an exception will be made or that a requirement will be waived for you.

9. *Temporary Licensure* – If an applicant is eligible for a temporary license, the temporary license will not be issued until the application and interview have been completed. The fee for a temporary license is $100 (Cashier's Check, Money Order or credit card payment via phone call only).

10. *License Renewal* – **Regardless of the date of issuance**, all licensees whose surnames begin with the letters A – L expire on June 30 of every even year, and all licensees whose surnames begin with letters M – Z expire on June 30 of every odd year. The full renewal fee will be required regardless of the date of initial licensure.

If you follow these suggestions in filling out your application, the process should proceed with few complications. We are committed to thoroughly reviewing credentials and to licensing qualified candidates in the shortest possible time.

Continuing Medical Education Requirements

The West Virginia Board of Medicine *requires* as a condition of **re-licensure** (renewal) that licensees be able to document **fifty (50)** hours of continuing education satisfactory to the West Virginia Board of Medicine *during the preceding two-year period.* Prior to the first license renewal, each licensee must complete two (2) hours in the subject of end-of-life care including pain management. These two hours shall be part of the 50 total hours required for renewal. (See §30-1-7a below).

The rule explaining what type of continuing education is considered satisfactory to the West Virginia Board of Medicine is available on our website at http://www.wvbom.wv.gov/CSR_11_06.asp. **Read this rule (11CSR6) carefully** as the provisions are *very important* for licensees who hold both active and inactive licenses.

Proof of your continuing medical education is to be sent to the Board at the time of licensure renewal. For those whose *last names begin with A through L*, the two-year period during which continuing education must be obtained began **July 1, 2010**, and ends **June 30, 2012**. For those whose *last names begin with M through Z,* the two-year period during which continuing education must be obtained began **July 1, 2009**, and ends **June 30, 2011**. No matter when your initial license is issued, your license will expire and must be renewed based on the schedule listed for the first letter of your last name.

ARTICLE 1. GENERAL PROVISIONS APPLICABLE TO ALL STATE BOARDS OF EXAMINATION OR REGISTRATION REFERRED TO IN CHAPTER.

§30-1-7a. Continuing education.

(a) Each board referred to in this chapter shall establish continuing education requirements as a prerequisite to license renewal. Each board shall develop continuing education criteria appropriate to its discipline, which shall include, but not be limited to, course content, course approval, hours required and reporting periods.

(b)(1) Notwithstanding any other provision of this code or the provision of any rule to the contrary, each person issued a license to practice medicine and surgery or a license to practice podiatry or a license as a physician assistant by the West Virginia board of medicine, each person licensed as a pharmacist by the West Virginia board of pharmacy, each person licensed to practice registered professional nursing or licensed as an advanced nurse practitioner by the West Virginia board of examiners for registered professional nurses, each person licensed as a licensed practical nurse by the West Virginia state board of examiners for licensed practical nurses and each person licensed to practice medicine and surgery as an osteopathic physician and surgeon or certified as an osteopathic physician assistant by the West Virginia board of osteopathy shall complete two hours of continuing education coursework in the subject of end-of-life care including pain management during each continuing education reporting period through the reporting period ending the thirtieth day of June, two thousand five. The two hours shall be part of the total hours of continuing education required by each board by rule and not two additional hours.

(2) Effective as of the reporting period beginning the first day of July, two thousand five, the coursework requirement imposed by this subsection will become a one-time requirement, and all licensees who have not completed the coursework requirement shall complete the coursework requirement prior to his or her first license renewal.

WEST VIRGINIA BOARD OF MEDICINE

101 DEE DRIVE, SUITE 103, CHARLESTON, WEST VIRGINIA 25311, (304) 558-2921, x221
www.wvbom.wv.gov

MEDICAL LICENSURE REQUIREMENTS

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

1. Graduation and receipt of the degree of doctor of medicine or its equivalent from a school of medicine, which is approved by the LCME or by the Board; and

2. **If an American, Canadian, or Puerto Rican graduate**, successful completion of at least one year of postgraduate clinical training (internship or residency) in the United States or Canada, which has been approved by the ACGME; or

   If a foreign medical graduate, successful completion of at least three (3) years of postgraduate clinical training (internship, residency or fellowship) in the United States or Canada, which has been approved by the ACGME, or successful completion of at least one such year and current certification by a member Board of the American Board of Medical Specialties; and

3. If a **foreign medical graduate, one** of the following:
   a. **Valid** ECFMG certificate; **or**
   b. Evidence of receipt of a passing score on the examination of the ECFMG, **or**
   c. Provided, that an applicant who: (i) is currently fully licensed, excluding any temporary, conditional or restricted license or permit, under the laws of another state, the District of Columbia, Canada or the Commonwealth of Puerto Rico; (ii) has been engaged on a full-time professional basis in the practice of medicine within the state or jurisdiction where the applicant is fully licensed for a period of at least five years; and (iii) is not the subject of any pending disciplinary action by a medical licensing board and has not been the subject of professional discipline by a medical licensing board in any jurisdiction, is not required to have a certificate from the educational commission for foreign medical graduates; and

4. **One** of the following:
   a. A FLEX Weighted Average (FWA) score of 75% or better obtained at one sitting on the FLEX (Federation Licensing Examination). Scores averaged together from two or more sittings will not be accepted; **or**
   b. A score of 75 or better on Component One of the FLEX **and** a score of 75 or better on Component Two of the FLEX; **or**
   c. A General average score of 75% or better on the National Board Examination; **or**
   d. Successful passage of a State Board Examination (the Puerto Rico examination is not accepted as it is not solely in English) **or** LMCC (Canadian Examination); **or**
   e. Successful passage of the USMLE (see next page); **or**
   f. Where a reciprocity agreement is in place, an applicant may provide evidence of 3.c. (i), (ii), and (iii).

Permanent license fee is $400.00 and $100.00 for a temporary license (**no personal checks accepted**). Fees are not refundable. A temporary license may be available to persons licensed in another state, the District of Columbia, Canada, or Puerto Rico. A temporary license is not available until the application and all supporting documents have been received and reviewed, the interview has been completed, and it has been determined there is no derogatory information from any other jurisdiction.

Qualification and Application for a License to Practice Medicine and Surgery

The Board (or a majority of them) shall accept a passing score of seventy-five (75) percent or better on Step three (3) of the USMLE, in lieu of a passing score on the FLEX, the NBME or LMCC certificate, or successful passage of a State Board examination. To be eligible for USMLE Step three (3), an applicant must have successfully completed and obtained passing scores of seventy-five (75) or better on **both** USMLE Steps one (1) and two (2). To be eligible for licensure an applicant **must successfully complete and obtain passing scores on USMLE Steps one (1), two (2) and three (3) within a period of ten (10) consecutive years**. **Each USMLE Step must be passed individually** in order to successfully complete the USMLE examination. An applicant who has failed to successfully complete and pass any one of the three steps of the USMLE in three attempts is required to appear before the Board for a determination by the Board, in its discretion, as to what, if any, further education, evaluation and training is required for further consideration of licensure.

The USMLE examination is designed to supersede and replace the FLEX examination and the National Board of Medical Examiners' examination sequence ("NBME") over a period of years, and some medical students and physicians may have successfully completed part of the FLEX or NBME examination sequence. In order to facilitate a smooth transition to USMLE and to avoid undue burden on applicants for licensure, it is necessary to designate those combinations of examinations which the Board will consider comparable to the existing examinations and which shall render an applicant eligible for licensure during the period of replacement of examinations. Those combinations and the passing score for each examination component are as follows:

a. NBME Part I (passing score = 75%) or USMLE Step 1 (passing score = 75%)
plus
NBME Part II (passing score = 75%) or USMLE Step 2 (passing score = 75%)
plus
NBME Part III (passing score = 75%) or USMLE Step 3 (passing score = 75%)

OR

b. FLEX Component 1 (passing score = 75%)
plus
USMLE Step 3 (passing score = 75%)

OR

c. NBME Part I (passing score = 75%) or USMLE Step 1 (passing score = 75%)
plus
NBME Part II (passing score = 75%) or USMLE Step 2 (passing score = 75%)
plus
FLEX Component 2 (passing score = 75%)

In order to meet the examination requirement of this subsection for licensure, **the examination combinations set forth in subdivisions a., b., and c., of this subsection, must be successfully completed within a period of ten (10) consecutive years**. An applicant who has failed to successfully complete and pass any one of the three steps of the USMLE in three attempts is required to appear before the Board for a determination by the Board, in its discretion, as to what, if any, further education, evaluation and training is required for further consideration of licensure.

INSTRUCTIONS FOR COMPLETING APPLICATION FOR PERMANENT MEDICAL LICENSURE

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

Pages 2 & 3: Answer all questions. Fraudulent 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 licensed or have EVER been licensed, regardless of the status or type of that license.** List all postgraduate training completed in the U.S. and/or Canada since graduation from medical school. Fraudulent answers may result in licensure denial or revocation.

Page 5: List all employment since graduation from medical school. See page 5 for further instructions.

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

Page 7: **You** must verify your medical license(s) from each state you **now hold or** have **ever** held, **regardless of the status of that license (i.e., active, inactive, lapsed, expired, suspended, surrendered, or revoked) or the type of license (permanent, temporary, locum tenens, education or training).** Most states require a fee, so check with each individual Board. Contact the Federation of State Medical Boards at (817) 868-4000 or www.fsmb.org for phone numbers for other State Boards. Many states (including West Virginia) use www.veridoc.org to process its verifications, or allow verification requests to other State Boards be completed on its web-site, which is an acceptable alternative to mailing this page. If not, send this page to make your request for verification. You may make extra copies of this page as necessary.

Page 8: **You** must send this page to each hospital where you have **EVER** participated in a postgraduate training program (internship, residency, and/or fellowship) in the United States or Canada. This page must be received in this office directly from the program. You may make extra copies of this page as necessary.

Page 9: **You** must send this page to your medical school for them to complete. For schools located in countries under Communist rule or presently engaged in civil war, we will accept **notarized letters from two (2) classmates, officials of the school, professors, etc.,** who will swear to your graduation and who were at the school the same time you were. **These letters must give the name of the school, the dates both you and the letter writer started and graduated (month, day, year).** The letters must be received by the WV Board of Medicine direct from the letter writer, not the applicant. **These letters will not be accepted by the Board just because it will take a long time to have your school complete Page 9.** It will be up to the Board office to determine which schools cannot or will not complete this page.

Page 10: This page is to be completed by another 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.**

Page 11: If you are a **foreign medical graduate** and relying on option 3.c. on page i, this page is to be completed by another medical doctor (not a D.O.) who is licensed in the state or jurisdiction where you have been engaged in the practice of medicine on a full-time professional basis for at least five years. The form must be notarized and sent to the Board with this application. Keep a copy of this completed form to take with you to your interview. **THIS IS NOT TO BE COMPLETED BY THE APPLICANT.**

AMA BIOGRAPHICAL PROFILE

You must contact the American Medical Association asking for a biographical profile, even if you are not a member of the AMA. There is a fee for this for non-members. Their phone number is 800-621-8335 or their web address is www.ama-assn.org/go/amaprofiles .

EXAMINATION REQUIREMENT

USMLE/FLEX: If applying for licensure on the basis of **USMLE, FLEX, or a combination of FLEX and USMLE,** you must request a transcript of your scores by completing the request form that is available on the Federation of State Medical Boards website at www.fsmb.org or by calling (817) 868-4000. **The scores must come directly to this office from the Federation.**

NATIONAL BOARDS: If applying for licensure on the basis of the **National Boards or a combination of National Boards and USMLE**, you must complete the request form for your scores available only on the NBME web site at http://examinee.nbme.org/interactive. **We will not accept any scores except those coming directly to this office from the National Boards.** (Phone: (215) 590-9700, option 5)

STATE BOARD: If applying for licensure on the basis of a **State Board Examination** or **LMCC**, you must request that state or jurisdiction to send your grades directly to this office. Most states require a fee for this, so contact that State Board. The Puerto Rico examination is not accepted as it is not solely in English. You may contact the Federation of State Medical Boards at (817) 868-4000 or visit their website at www.fsmb.org for phone numbers for other State Boards.

ADDITIONAL INSTRUCTIONS

You MUST submit the following with your portion of the application:

1. **Copy** of your medical school diploma. (A notarized copy of an official[1] translation is needed if your diploma is in other than English or Latin.)

2. **American, Canadian, or Puerto Rican medical school graduates:** **Copy** of your certificate* of completion of at least one (1) year ACGME approved postgraduate clinical training (internship or residency), in the United States or Canada; **OR**

   Foreign medical school graduates: **Copy** of your certificate* of completion of at least three (3) years of ACGME approved postgraduate clinical training (internship, residency or fellowship), in the United States or Canada, **OR** of at least one year of ACGME approved postgraduate training plus proof of current certification by a member Board of the American Board of Medical Specialties.

   *If you have not yet received your certificate, proof of completion can be in the form of an official letter (indicating beginning and ending dates of training) from the program director, with the School or Hospital Seal affixed. You need to keep the original letter to take with you on your interview. Submit a **copy** of the letter with your application. This is in addition to page 8 of the application.

3. If you are a **foreign medical school graduate,** a **valid** copy of your ECFMG certificate (or evidence of receipt of a passing score on the examination); **or** the original Affidavit (page 11) attesting to at least five (5) years of full-time practice within the state or jurisdiction where you are fully licensed. To rely on this option, your application must show that you are currently fully licensed (excluding any temporary, conditional or restricted license or permit) under the laws of another state, the District of Columbia, Canada or the Commonwealth of Puerto Rico, **and** that you are not the subject of any pending disciplinary action by a medical licensing board and have not been the subject of professional discipline by a medical licensing board in any jurisdiction.

4. **Copy** of your birth certificate, passport, or baptismal record. No other documents accepted in lieu of this.

5. **Copy** of your marriage license, divorce decree, or court order of change of name if the name shown on your diploma is not the name you are now using. **You will be licensed under the name shown on your medical diploma if evidence is not provided to the Board of a change of name.**

6. **Cashier's Check or Money Order** (no personal checks) made payable to the WEST VIRGINIA BOARD OF MEDICINE in the amount of **$400.00** for the permanent license fee. **This fee is not refundable under any circumstances.**

7. **National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB):** This is required of all applicants. Please contact the NPDB/HIPDB at 1-800-767-6732 to request the "Practitioner Request for Information Disclosure" self-query form. You may also find this form on their website at www.npdb-hipdb.hrsa.gov. Once you receive the form, complete it in its entirety; sign in the presence of a notary, and forward to the NPDB/HIPDB. The NPDB/HIPDB will generate a combined report (one for each data bank) and return this report to you. You **MUST** submit all of the **ORIGINAL** report (not photocopies) to this office.

[1]An official translation is one which is done by:

1. a government official in the U.S.
2. an official translation service in the U.S. and is qualified to translate.
3. a professor of a language department in a college or university located in the U.S.
4. an Official of the American Embassy in a foreign country. (This document must be translated by the American Embassy, not just certified as a true copy and must have the Embassy seal placed on it.)

The translator must:

1. Certify that the document is a true translation to the best of his/her knowledge, that he/she is fluent in the language.
2. Sign the translation and his/her signature must be certified by a Notary Public.
3. Print his/her name and title under the signature.
4. Translate on official letterhead

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 (including all supporting documentation requested on page iv), **BEFORE** you may schedule your interview with a Board Member. **Do not** contact a Board member to schedule your appointment for the interview until you have received the interview form mailed to you from the Board office. This interview must be completed at least fifteen (15) 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 question on Page 3 of the application, you may be required to appear before the Licensure Committee instead of an interview with a Board member and you may not be eligible for a temporary license.

AT THE INTERVIEW, YOU MUST PRESENT THE FOLLOWING: (No Exceptions)

1. Your **original** medical school diploma (with **original** official translation if your diploma is in other than English or Latin); **AND**

2. Your **original** evidence of at least one (1) year postgraduate clinical training in the United States or Canada (certificate or official letter with School Seal affixed from the program director), if you are an American, Canadian, or Puerto Rican medical school graduate; **OR**, if you are a foreign medical graduate, your **original** evidence of at least three (3) years postgraduate clinical training in the United States or Canada (certificate or official letter with School Seal affixed from the program director), **OR** successful completion of at least one such year and current certification by a member Board of the American Board of Medical Specialties; **AND**

3. If you are a foreign medical graduate, your **original** valid ECFMG certificate **OR original** evidence of receipt of a passing score on the ECFMG examination, Provided, that an applicant who (i) is currently fully licensed, excluding any temporary, conditional or restricted license or permit, under the laws of another state, the District of Columbia, Canada or the Commonwealth of Puerto Rico; (ii) has been engaged on a full-time professional basis in the practice of medicine within the state or jurisdiction where the applicant is fully licensed for a period of at least five (5) years; and (iii) is not the subject of any pending disciplinary action by a medical licensing board and has not been the subject of professional discipline by a medical licensing board in any jurisdiction, is not required to have a certificate from the ECFMG, but must produce a photocopy of the Affidavit (Page 11) attesting to five (5) years of full-time practice within the state or jurisdiction where currently licensed.

The original documents produced at the interview must conform with the copies submitted with your application.

If you are eligible for a temporary license (see page i) and request a temporary license be issued between the time your application is completed (including the interview) and the Board meeting at which it will be presented, an additional fee of **$100.00** is required, in the form of a **Cashier's Check, Money Order (no personal checks) or by credit card via a phone call and is not refundable. Payment of this fee does not guarantee you a temporary license.** The granting of a temporary license occurs in writing from the Board office. If you have any derogatory information against you or have answered "yes" to any of the questions on page 3, you may not be eligible for a temporary license.

The West Virginia Board of Medicine will provide reasonable accommodation to a qualified applicant with a disability in accordance with the Americans with Disabilities Act.

APPLICANT'S CHECKLIST

This checklist is provided for your convenience. You should keep this and the instructions to refer to during the application process. Please see the preceding pages of instructions for specific information.

Application Materials	To be submitted to the Board office by applicant	To be submitted to the Board office by third party	Documentation provided by FCVS*
Page 1 with photograph & signature	√		
Page 2 current signature & date	√		
Page 3 signed & dated, with any attachments	√		
Page 4 complete all sections	√		
Page 5 c.v. not accepted in lieu of this	√		
Page 6 signature must be notarized	√		
Page 7 to request licensure verifications		√	
Page 8 send to each PG training program		√	√
Page 9 send to medical school		√	√
Page 10 to be completed by an M.D.		√	
Page 11 send to Board office[1], if applicable	√		
Appendix A for judgments or settlements only	√		
AMA Biographical Profile		√	
Application Fee (no personal checks)	√		
Exam Scores (i.e., USMLE, FLEX, NBME)		√	√
NPDB *and* HIPDB report[2]	√		
Copy of medical school diploma	√		√
Copy of diploma translation, if necessary	√		√
Copy of postgraduate training certificates	√		
Copy of ECFMG certificate[3]	√		√
Copy of birth certificate, passport, or baptismal	√		√
Copy of proof of name change[4]	√		√

*If you are using FCVS, the items checked in this column should be provided by the FCVS. However, if your FCVS packet does not contain this information, you will be responsible for providing or requesting the information.

[1]For foreign medical graduates who do not have ECFMG certification.
[2]When you receive the report from NPDB *and* HIPDB, forward all of the originals to the Board office.
[3]For foreign medical graduates only.
[4]Marriage certificate, divorce decree, or court document.

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.

WEST VIRGINIA BOARD OF MEDICINE

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

OFFICE USE ONLY

Int.__________

Date____/____/____

TMP__________

Issued____/____/____

Perm.__________

Issued:____/____/____

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

I am applying for licensure by endorsement of examination of (check only one):

______NBME ______USMLE ______FLEX ______LMCC

______USMLE/FLEX ______NBME/USMLE ______State Board Exam of ______

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:________________ If not currently working as a medical doctor, check here ☐

(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 Medical School:________________________________

________________________________Date of Graduation:______/______/______

(MM/) (DD) (YY)

Practice Specialty:____________________ Proposed WV practice location:____________________

Board Certified in: ________________________ Date Board Certified:______/______/______

(MM) (DD) (YY)

ATTA CH CHECK HERE

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:

Revised 04/07

APPLICATION CERTIFICATION

I hereby certify that I have read the instructions (pages i through viii) explaining the medical licensure requirements for the State of West Virginia, and I understand what I have read and what I am required to produce for medical 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 medical licensure in the State of West Virginia. I hereby certify that I am able to meet all these requirements for medical 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'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 medical 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'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's Signature:______________________________ Date:______________

READ EVERYTHING ON THIS PAGE CAREFULLY AND COMPLETELY
FALSE OR FRAUDULENT ANSWERS TO THE FOLLOWING QUESTIONS MAY RESULT IN LICENSURE DENIAL OR REVOCATION

Have you ever, 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 the practice of medicine, 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 license to practice, or had your 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 license to practice medicine?........	______	______
6. ††had any hospital privileges, and/or postgraduate training, 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 licensure in any state or been ejected from any medical examination?........	______	______
9. been denied a license to practice medicine?........	______	______
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 judgments or settlements arising from medical professional liability rendered or made against you, and if so, how many?__________........	______	______
Have you in the last five (5) years, in any jurisdiction:		
13. **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?........	______	______
14. had any interruption in your practice of medicine 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?........	______	______
15. 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's Signature:______________________________ **Date:**______/______/______

IMPORTANT INFORMATION

If you answered "YES" to any of the above questions, you MUST furnish full details on an 8½ x 11 sheet of paper which MUST be attached to this application. On attachment, please include your name and the page number of the 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 court 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, for each judgment or settlement you MUST complete Appendix A, which is attached to this application. If more than one judgment or settlement, you may make copies of Appendix A.

**If you answered "YES" to Question 13 and have gone through a rehabilitation program, you MUST have that program furnish this Board a report of your treatment and progress.

Applicant's Name (Last, First, Middle)

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 medical license, including those where your application was withdrawn.

I have applied for licensure in the following states:	Year	Granted		Permanent or Temporary	License Number	Licensure Based Upon:					Status (See list above)
		Yes	No			FLEX	NBME	State Board	USMLE	LMCC	

POST GRADUATE MEDICAL EDUCATION TRAINING

List all post graduate medical education training (i.e., internship, residency, fellowship) since graduation from medical school with dates and complete addresses of institutions. Do not list practice ex perience.

Beginning Date MM/DD/YY	Ending Date MM/DD/YY	Name of Hospital/Institution	Address	Completed? Yes/No

HOSPITAL PRIVILEGES

List all hospitals where you have held staff privileges of any type in the last five (5) years.

From	To	Name of Hospital	Address	Status

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.

Applicant's Name (Last, First, Middle)

PROFESSIONAL ACTIVITIES

List in chronological order all of your professional activities and/or places of employment since graduation from medical school. This includes hospitals, teaching institutions, HMO's, private practice, corporations, military assignments, government agencies, and Locum Tenens assignments. Exclude postgraduate training (internship, residency, fellowship) listed on page 4. Also, include all periods of unemployment. List all employment outside of medicine since graduation from medical 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 THE PRACTICE OF MEDICINE

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 to which the attachment corresponds. Provide complete information. Otherwise, requesting additional information from you may lengthen the application process.

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 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

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:____

LICENSE METHOD:
( ) National Board
( ) State Board Exam
( ) USMLE
( ) FLEX
( ) Reciprocity/Endorsement with:____________________
( ) Other____________________

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 license to practice medicine 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 medicine, in your state?
YES________ NO________ UNABLE TO DIVULGE______ **(If yes, please attach details)**

COMMENTS:____

____

SIGNED____

BOARD SEAL

TITLE____

DATE____

West Virginia Board of Medicine
101 Dee Drive, Suite 103, Charleston, WV 25311, Phone: (304) 558-2921; www.wvbom.wv.gov

This section to be completed by the applicant.
In applying for a license to practice medicine and surgery, the West Virginia Board of Medicine requires this form to be completed by each hospital wherein I participated in any postgraduate training program in the United States or Canada. 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:______________________________,M.D. DOB:______/______/______

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

Program:______________________ Dates of Training:____/____/______ to ____/____/______

Signature:______________________________ Date:______/______/______

This section is to be completed by the Program Director.
Attention Program Director: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named above satisfactorily completed a period of postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility		Address of Facility
Program Participation: Report incomplete postgraduate years (PGY) separate from those successfully completed	PGY:________ ____ Internship ____ Residency ____ Chief Residency ____ Fellowship ____ Research	Specialty/Subspecialty:______________ From:____/____/____ To: ____/____/____ Successfully completed? ____Yes ____No ____In Progress Accredited by: ____ACGME ____RCPSC
If the postgraduate year is currently in progress, report the expected completion date in the "To" field.	PGY:________ ____ Internship ____ Residency ____ Chief Residency ____ Fellowship ____ Research	Specialty/Subspecialty:______________ From:____/____/____ To: ____/____/____ Successfully completed? ____Yes ____No ____In Progress Accredited by: ____ACGME ____RCPSC
Report Internships, Residencies, and Fellowships separately.	PGY:________ ____ Internship ____ Residency ____ Chief Residency ____ Fellowship ____ Research	Specialty/Subspecialty:______________ From:____/____/____ To: ____/____/____ Successfully completed? ____Yes ____No ____In Progress Accredited by: ____ACGME ____RCPSC
Unusual circumstances: Circle the correct response. Omitted responses require written explanation. If necessary, you may continue your explanation on a separate sheet of paper	Did this individual ever take a leave of absence or break from his/her training? Yes No Was this individual ever placed on probation? Yes No Was this individual ever disciplined or placed under investigation? Yes No Were any negative reports ever filed by instructors? Yes No Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes No Please explain any "Yes" response from above:______________	
Certification: ~~Affix your institutional~~ seal in this space; if no seal is available, you must have this form notarized.	Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only). Name:______________ Signature:______________ Title:______________ Date of Signature:____/____/____	

MEDICAL EDUCATION VERIFICATION

This section to be completed by the applicant.
In applying for a license to practice medicine and surgery , the West Virginia Board of Medicine requires this form to be completed by the medical school wherein I received my doctor of medicine (M.D.) 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:______________________________,M.D. DOB:______/______/______

Name as issued on diploma, if different from above:______________________________, M.D.

Date of Graduation: ______/______/______ SSN:______-______-______

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

Signature:______________________________ Date:______/______/______

CERTIFICATE OF DEAN, SECRETARY, OR REGISTRAR OF MEDICAL COLLEGE

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

This is to certify that ______________________________
(Name of Graduate)

has satisfactorily completed ______________ years of medical education at the

______________________________, located at
Name of Medical 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 iii)

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 engaging in the practice of medicine and surgery.

____
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

Appendix A

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

Professional Liability Claim Report Supplied by the Applicant

This form is to be used as supporting documentation for page 3, question 12, of the application for licensure. Please complete this form for each professional liability judgment or settlement. Do not include pending or dismissed cases. You may make copies of this page if more than one judgment or settlement. This form will be returned to you if you do not provide the exact date and amount of the judgment or settlement.

Applicant's Name____
(Last, First, Middle, Suffix)

Name and Address of Insurance Company____

____
Street Address or P.O. Box   City   State   Zip

Claimant's Name____

Date of Loss_______/_______/_______
MM DD YYYY

Date of Judgment_______/_______/_______ **Amount**______________________
MM DD YYYY

or

Date of Settlement_______/_______/_______ **Amount**______________________
MM DD YYYY

Reason for Settlement____

____

Additional Information____

____

____

____

Applicant's Signature______________________________ **Date of Signature:**_____/_____/_____
MM DD YYYY

Revised 4/07

This section to be completed by the applicant.
If you are a **foreign medical graduate** and relying on option 3.c. on page i of the application instructions, this page is to be completed by another medical doctor (not a D.O.) who is licensed in the state or jurisdiction where you have been engaged in the practice of medicine on a full-time professional basis for at least five years. The form must be notarized and sent to the Board with this application. Keep a copy of this completed form to take with you to your interview.

Name:______________________________,M.D.

Address:______________________________
Mailing Address City State Zip

AFFIDAVIT

The following Affidavit is made upon my personal knowledge and I am competent to testify as to the matters stated herein.

I, ______________________________, M.D., being first duly sworn, do state as follows: that I
(Name of Affiant) (See Instructions, Page iii)

am currently licensed to practice medicine in the state/jurisdiction of ______________________________,

and the applicant ______________________________, M.D., has been engaged on a
Name of Applicant

full-time professional basis in the practice of medicine in this state/jurisdiction for a period of at least five (5) years.

______________________________ ______________________________
Signature of Affiant Printed Name of Affiant

____
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 original form to:

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