Volume 13, Issue 3

July 2009
-
September 2009

West Virginia Board of Medicine Quarterly Newsletter

The Patients Doctors Don't Know

By ROSANNE M. LEIPZIG

(Reprinted from July 2, 2009, New York Times, with the author's permission)

As they do every July, hospitals across America are welcoming new interns, fresh from medical school graduation. Given how much these trainees have yet to learn, common wisdom holds that it's not a good time of year to get sick. This may be particularly true for older patients, because American medical schools require no training in geriatric medicine.

Often even experienced doctors are unaware that 80-year-olds are not the same as 50-year-olds. Pneumonia in a 50-year-old causes fever, cough and difficulty breathing; an 80-year-old with the same illness may have none of these symptoms, but just seem "not herself" — confused and unsteady, unable to get out of bed.

She may end up in a hospital, where a doctor prescribes a dose of antibiotic that would be right for a woman in her 50s, but is twice as much as an 80-year-old patient should get, and so she develops kidney failure, and grows weaker and more confused. In her confusion, she pulls the tube from her arm and the catheter from her bladder.

Instead of re-evaluating whether the tubes are needed, her doctor then asks the nurses to tie her arms to the bed so she won't hurt herself. This only increases her agitation and keeps her bed-bound, causing her to lose muscle and bone mass. Eventually, she recovers from the pneumonia and her mind is clearer, so she's considered ready for discharge — but she is no longer the woman she was before her illness. She's more frail, and needs help with walking, bathing and daily chores.

This shouldn't happen. All medical students are required to have clinical experiences in pediatrics and obstetrics, even though after they graduate most will never treat a child or deliver a baby. Yet there is no requirement for any clinical training in geriatrics, even though patients 65 and older account for 32 percent of the average doctor's workload in surgical care and 43 percent in medical specialty care, and they make up 48 percent of all inpatient hospital days. Medicare, the national health insurance for people 65 and older, contributes more than $8 billion a year to support residency training, yet it does not require that part of that training focus on the unique health care needs of older adults.

-continued on page 2-

INSIDE THIS ISSUE

The Patients Doctors Don't Know

By ROSANNE M. LEIPZIG

-continued from page 1-

Medicare beneficiaries receive care from doctors who may not have been taught that heart attacks in octogenarians usually present without chest pain, or that confusion can be due to bladder infections, heart attacks or Benadryl. They do not routinely check for memory problems, or know which community resources can help these patients manage their conditions. They're uncomfortable discussing goals of care, and recommend screening tests and treatments to patients who are not going to live long enough to reap the benefits.

I was part of a group of doctors and medical educators who recently published in the journal Academic Medicine a set of minimum abilities that every medical student should demonstrate before graduating and caring for elderly patients. Nicknamed the "don't kill Granny" list, it includes being able to prescribe medicines, assess patients' ability to care for themselves, recognize atypical presentations of common diseases, prevent falls, recognize the hazards of hospitalization and decide on treatments based on elderly patients' prognosis and their personal preferences.

The 2008 Institute of Medicine report "Retooling for an Aging America" resolved that all licensed health care professionals should be required to demonstrate such competence in the care of older adults. But this resolution lacks teeth. Medical resident training programs that receive Medicare money should be required to demonstrate that their trainees are competent in geriatric care. Medicare should finance medical training in nursing homes. And state licensing and medical specialty boards should require demonstration of geriatric competence for licensing and certification.

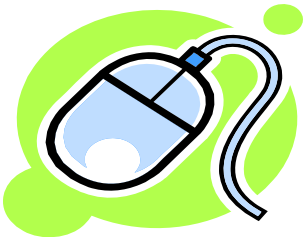
Basic geriatric knowledge is preventive medicine. Nurses, social workers, pharmacists and other health care professionals should have it, too, in order to improve care for older people. But until doctors get this basic training, we can't even begin to give 80-year-olds the care they need.

Rosanne M. Leipzig, a physician, is a professor at Mount Sinai School of Medicine.

RECOMMENDATION ON PETS IN YOUR OFFICE

The Board of Medicine recommends that while it is unable to find West Virginia laws, rules or policies in place regarding a physician, podiatrist or physician assistant bringing his or her pets to the office, the Board of Medicine suggests that for purposes of sanitation, safety, and possible liability, it is sensible and appropriate not to allow your pets in patient care and common areas of your offices.

Do not confuse this recommendation with the "Public Policy Statement on the Admission of Service Animals to Physicians' and Podiatrists' Offices and Other Health Care Settings" adopted by the Board of Medicine on September 14, 2009 (see page 8 and 9 of this Newsletter).



THE BOARD'S WEBSITE ADDRESS HAS CHANGED TO:

www.wvbom.wv.gov

NEW APPOINTMENT TO THE BOARD

Effective September 22, 2009, Governor Manchin appointed **G. Mark Moreland, M.D.**, to serve as a member of the Board. Dr. Moreland is a family practitioner who practices in Nitro, West Virginia, and will serve with a term expiring September 30, 2012. We welcome Dr. Moreland.

Medical Economics Says the Mountain State is One of the Best Places for Doctors to Practice

By Paul Darst

(Reprinted from the State Journal with permission of the author)

The July edition of Medical Economics magazine contained what might be a surprise to a lot of West Virginians. The publication named the Mountain State as one of the 10 best places for physicians to practice. West Virginia ranked ninth on the list.

The positives the article listed included the state's relatively low unemployment rate, which was 7.5 percent at the time the magazine was published. That was well below the national rate and the rates of neighboring states at the time.

Another positive was that the state saw income increase in 2008 as opposed to decreases in the rest of the nation. The magazine quoted a recruiter who said some annual compensation packages for doctors who come to West Virginia run $200,000 to $225,000.

Meanwhile, Medical Economics lists the state's median annual primary care compensation at $151,500, which was the lowest listed in the article.

West Virginia came in just ahead of Alaska, which was ranked at 10. The rest of the list was:

8. Alabama
7. Minnesota
6. Oregon
5. New Hampshire
4. North Dakota
3. Indiana
2. Wisconsin
1. Texas

Although West Virginia made the list, the article did mention some negatives about practicing here.

"Despite reforms in 2001, malpractice liability insurance rates, while on the downward trend, are still some of the most expensive among the 10 Best Places to Practice," the journal said. "The state is also gradually enacting a number of corporate and income tax reforms, which add to an already higher than average tax burden, according to the Tax Foundation."

West Virginia's malpractice insurance rate listed in the article at $20,528 to $23,057 per year. The only other state on the list that comes close is Texas, which has a rate range of $8,839 to $31,668. The median rate in Texas, however, is $16,674.

Medical Economics lists Beckley as the "Best town you've never heard of."

BOARD ACTIONS
July 2009 — September 2009

DONAHOE, DORVAL HENDRIX, M.D. – Logan, WV (08/10/2009) WV License No. 8694
Board Conclusion: Relating to unprofessional conduct and the renewal of a license to practice medicine and surgery by making an incorrect statement in connection with a licensure application.
Board Action: Dr. Donahoe shall pay to the Board a CIVIL FINE in the amount of $100 per credit hour for his prior deficiency of two (2) hours of continuing medical education for the licensure renewal period from July 1, 2006, to June 30, 2008, together with a one (1) time ADMINISTRATIVE FEE in the amount of $100, for a total of $300.

HESS, ROBERT ALBERT, M.D. – Huntington, WV (08/05/2009) WV License No. 14997
Board Conclusion: Relating to unprofessional conduct and the renewal of a license to practice medicine and surgery by making an incorrect statement in connection with a licensure application.
Board Action: Dr. Hess shall pay to the Board a CIVIL FINE in the amount of $100 per credit hour for his prior deficiency of two (2) hours of continuing medical education for the licensure renewal period from July 1, 2006, to June 30, 2008, together with a one (1) time ADMINISTRATIVE FEE in the amount of $100, for a total of $300.

KLEIN, CAROL ANGELA, M.D. – Huntington, WV (09/14/2009) WV License No. 16597
Board Conclusion: Relating to unprofessional conduct and the renewal of a license to practice medicine and surgery by making an incorrect statement in connection with a licensure application.
Board Action: Dr. Klein shall complete ten and one half (10½) hours of Category I-AMA CME and document her completion within thirty (30) days of the entry date of the Consent Order. Dr. Klein shall also pay a CIVIL FINE in the amount of $100 per credit hour for her deficiency of ten and one half (10½) hours of CME for the licensure renewal period from July 1, 2006, to June 30, 2008, together with a one (1) time ADMINISTRATIVE FEE in the amount of $100, for a total of $1,150. Dr. Klein was PUBLICLY REPRIMANDED for her failure to complete the required continuing medical education and for misrepresenting on her licensure renewal application that she had completed the required minimum number of hours.

MAY, BILLY PAUL, D.P.M. – Huntington, WV (08/10/2009) WV License No. 133
Board Conclusion: Unprofessional conduct.
Board Action: License SURRENDERED effective August 10, 2009, and Dr. May agrees not to apply to the Board for licensure in the future, and if he does, his application will be denied.

OKOH, JAMES IKEMEFUNA, M.D. – Eden Prairie, MN (08/24/2009) WV License No. 23341
Board Conclusion: License to practice medicine in the State of Florida was acted against or subjected to other discipline.
Board Action: PUBLICLY REPRIMANDED for having his license acted against by the licensing authority in the State of Florida.

POLAVARAPU, PADMAJA, M.D. – Bland, VA (09/28/2009) WV License No. 17433
Board Conclusion: Unprofessional, unethical, and dishonorable conduct, and having her license acted against in another state.
Board Action: The February 12, 2009, Consent Order Dr. Polavarapu and the Board entered into was amended to include the practice of medicine in an urgent care facility or setting.

RAMAKRISHNAN, KARTHIK, M.D. – Kingsport, TN (07/15/2009) WV License No. 23744
Board Conclusion: Relating to presenting a false statement in connection with an application for a license.
Board Action: Dr. Ramakrishnan, having met the requirements for the issuance of a license to practice medicine and surgery in the State of West Virginia, was granted a license and was PUBLICLY REPRIMANDED for providing inaccurate information to the Board on his licensure applications to the West Virginia Board of Medicine and earlier to the Tennessee Board of Medical Examiners.

RAMESH, H.S., M.D. – Charleston, WV (09/09/2009) WV License No. 17815
Board Conclusion: Relating to unprofessional conduct, making a deceptive, untrue or fraudulent representation in the practice of medicine, and exercising influence on a patient in such a way as to exploit the patient for financial gain of the physician.
Board Action: Dr. Ramesh shall pay a CIVIL FINE in the amount of one thousand dollars ($1,000).

-continued on page 5-

BOARD ACTIONS
July 2009 — September 2009

-continued from page 4-

RECINE, CARL ALBERT, M.D. – Coeur D'Alene, ID (08/28/2009) WV License No. 23547
Board Conclusion: Relating to having his license in another jurisdiction acted against and subjected to disciplinary action.
Board Action: PUBLICLY REPRIMANDED for having his license in another jurisdiction acted against and subjected to disciplinary action.

SAVIT, RUSS MARC, M.D. – Coeur D'Alene, ID (09/01/2009) WV License No. 21264
Board Conclusion: Relating to having his license in another jurisdiction acted against and subjected to disciplinary action.
Board Action: PUBLICLY REPRIMANDED for having his license in another jurisdiction acted against and subjected to disciplinary action.

SHAH, DINESH BABUBHAI, M.D. – North East, MD (09/14/2009) WV License No. 12341
Board Conclusion: Non-compliance with terms and conditions of the May 27, 2009, Consent Order entered into between Dr. Shah and the West Virginia Board of Medicine.
Board Action: License REVOKED effective September 15, 2009, at 12:01 a.m.

SHIFFLER, JOEL DAVID, M.D. – Parkersburg, WV (07/13/2009) WV License No. 20094
Board Conclusion: Has not made a good faith effort to comply with the terms of the Amended Consent Order he entered into with the Board in February 2008.
Board Action: License REVOKED effective July 15, 2009, at 12:01 a.m.

VAN DEREN, III, JOHN MEDEARIS, M.D. – Ashland, KY (07/13/2009) WV License No. 20097
Board Conclusion: On May 4, 2009, the Circuit Court of Boyd County, Kentucky, Division II, found Dr. Van Deren guilty of two (2) felonies: possession of a controlled substance/cocaine, first degree, first offense; and possession of a controlled substance/opiates, first degree, first offense, and he was found guilty of three (3) related misdemeanors: operating a motor vehicle while under the influence of drugs, first offense; possession of a controlled substance, second degree, first offense; and prescription controlled substances not in original container, first offense.
Board Action: Under the provisions of West Virginia Code, the Board shall revoke the license of any physician who is found guilty by any court of competent jurisdiction of any felony involving prescribing, selling, administering, dispensing, mixing or otherwise preparing any prescription drug, including any controlled substance under state or federal law, for other than generally accepted therapeutic purposes. Accordingly, the Board REVOKED the license to practice medicine and surgery of Dr. Van Deren, effective July 15, 2009, at 11:59 p.m.

LICENSURE DENIAL

HABASHI, MAHER F., M.D. - Lincolnton, NC (07/13/2009)
Board Conclusion: Unqualified to practice medicine and surgery in the State of West Virginia, due to dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public or any member thereof; engaging in unprofessional conduct, including, but not limited to, any departure from, or failure to conform to the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or has committed any act contrary to honesty, justice or good morals, whether the same is committed in the course of his practice or otherwise and whether committed within or without this State; and failure to practice medicine with that level of care, skill and treatment which is recognized by a reasonable, prudent physician engaged in the same or similar specialty as being acceptable under similar conditions and circumstances.
Board Action: License DENIED effective July 13, 2009.
Notice of Appeal: In August, 2009, Dr. Habashi APPEALED the Board's decision. A hearing is scheduled for October 28, 2009, in the Board Offices.

PROTECT YOUR IDENTITY!

A group of unknown individuals are soliciting personal identification information from physicians through various corrupt schemes. Once obtained, the personal information is being used to complete fraudulent Medicare provider applications for new practice locations. Once the new provider number is established, these individuals rapidly submit a large volume of claims to the Medicare carrier for payment.

Common Sense Tips:

1. Perform rigorous research regarding opportunities presented to you when making application for joint venture opportunities of companies unknown to you.
2. Remove any unnecessary personal identifying information from outgoing correspondence.
3. Do not post your resume on line, especially if it contains any confidential personal identifying information.
4. Remember, no one from Medicare will contact you to verify your Medicare numbers. They already have this information.
5. Don't leave laptops or other gateways into your personal information unattended.
6. Cancel computer access immediately when anyone leaves your employment.
7. Perform rigorous research regarding the company you intend to work for when applying for employment prior to sharing any personal information.
8. Check with your carrier to see what practice locations they have listed for you.
9. Contact the OIG Hotline if you suspect you are the victim of provider identity theft:

Phone:	1.800.HHS.TIPS (1-800-447-8477)
Fax:	1.800.223.8164
TTY:	1.800.377.4950
E-Mail:	HHSTips@oig.hhs.gov
Mail:	Office of Inspector General Department of Health and Human Services Attn: HOTLINE P. O. Box 23489 Washington, DC 20026

VERIFICATIONS OF LICENSES

Effective November 1, 2009, the West Virginia Board of Medicine announces its partnership with Veri-Doc, Inc., in offering a fully automated, internet based, license verification system. Based in North Dakota, VeriDoc is utilized by twenty-five (25) state medical boards nationwide. It provides a fast, convenient, and efficient method of processing written primary source verifications and has been applauded by state medical boards, physicians, licensing services, and other users. Medical doctors are able to send multiple verifications to multiple boards in a single transaction by simply logging on to the VeriDoc website at www.veridoc.org. Verifications will be provided immediately when using VeriDoc, thereby greatly reducing paperwork and time. VeriDoc will also handle primary source verification requests for physician assistants. Written primary source verification for podiatrists, however, will continue to be handled by the Office of the Board of Medicine through the traditional paper process. The cost for using VeriDoc for West Virginia will be $35.00 and is in keeping with costs for such services in other states.

VeriDoc will NOT replace the public search system available on the West Virginia Board of Medicine website. Those who seek to find information concerning a medical doctor in West Virginia, including the status of his or her license, may continue to do so using the Board of Medicine website search engine.

Those calling the Board of Medicine seeking written primary source verification will be routed to the VeriDoc website beginning November 1, 2009. You may call the Board of Medicine if you have any questions regarding this service.

About the One & Only Campaign

The goal of the One & Only Campaign is to improve safe injection practices across healthcare settings. The practices within an organization are highly influenced by its culture or are an expression of its culture. Thus, through education, outreach, and grassroots initiatives, the One & Only Campaign will seek to influence the culture of patient safety. The One & Only Campaign is an education and awareness campaign aimed at both healthcare providers and the public to increase proper adherence to safe injection practices to prevent disease transmission from the misuse of needles, syringes, and medication vials in outpatient settings. While the campaign will be initially rolled out in targeted locations, the vision is to develop a concept that can be replicated nationwide. For more information, please visit:

www.ONEandONLYcampaign.org

Coalition partners include the following organizations: Accreditation Association for Ambulatory Health Care (AAAHC), American Association of Nurse Anesthetists (AANA), Ambulatory Surgery Foundation, Association for Professionals in Infection Control and Epidemiology, Inc (APIC), BD (Becton, Dickinson and Company), Centers for Disease Control and Prevention (CDC), CDC Foundation, HONOReform Foundation, Nebraska Medical Association (NMA), and Nevada State Medical Association (NSMA).

PUBLIC POLICY STATEMENT ON THE ADMISSION OF SERVICE ANIMALS TO PHYSICIANS' AND PODIATRISTS' OFFICES AND OTHER HEALTH CARE SETTINGS

Adopted by the Board on September 14, 2009

Health care facilities, including doctor's offices, are covered under the Americans with Disabilities Act (ADA) as places of public accommodation. Places of public accommodation have a legal duty to make modifications of rules and policies when necessary to accommodate individuals with disabilities. 28 C.F.R. §36.202(c); W.Va. Code R. §77-1.7.7.

The ADA allows the use of service animals for the benefit of individuals with disabilities. An individual with a disability is a person with a "physical or mental impairment that substantially limits one or more major life activities of such individual." 42 U.S.C. §12102(2)(A).

The implementing regulations of the ADA provide that a service animal is "any guide dog, signal dog, or other animal individually trained to do work or perform tasks for the benefit of an individual with a disability, including, but not limited to, guiding individuals with impaired vision, alerting individuals with impaired hearing to intruders or sounds, providing minimal protection or rescue work, pulling a wheelchair or fetching dropped items." 28 C.F.R. § 36.104. This list is not exhaustive.

The ADA does not require specific identification or certification of these animals. Policies requiring proof of certification or similar documentation are in violation of the ADA.

Providers may ask if the animal is a service animal and may ask what tasks the animal has been trained to perform (although questions regarding the individual's specific disability are prohibited). The person seeking admission of the service animal need only identify himself/herself as a person with a disability, that he or she has a service animal, and describe the training of the animal.

Unless there is evidence that the presence or use of a service animal would pose a significant risk, the assumption should be that the service animal should be permitted to accompany its owner wherever that person goes. Places of public accommodation must permit the use of a service animal by a person with a disability unless the use would create a fundamental alteration of the provider's goods, services and/or accommodations or would pose a direct threat to the safety of others or the facility. The determination of a fundamental alteration or a direct threat to safety is fact specific, and is thus a case-by-case determination. The Department of Justice (DOJ) has recognized that service animals could pose a significant health risk in certain areas of a hospital. In determining the risk, the DOJ has stated that the determination of risk should be made by appropriate medical personnel. Note that under the ADA, a place of public accommodation may impose certain restrictions if those restrictions are based on an analysis of "actual risks and not on mere speculation, stereotypes or generalizations about individuals with disabilities." 28 C.F.R. §36.301 (b). Such considerations as the level of sterility precautions utilized and the presence of immunosuppressed patient populations have been suggested as legitimate considerations.

Once a finding of risk has been made, the medical personnel should list areas where exclusion is appropriate and permit service animals in all other areas. DOJ Technical Assistance Letter, Doc.302, May 10, 1993, Danforth, John C., service animals in hospitals.

The person with a disability who seeks admission of a service animal is responsible for the care of that animal, including providing supervision of the animal if separation is required to avoid a fundamental alteration or threat to safety. 28 C.F.R. 36.302(c)(2).

The CDC and Healthcare Infection Control Practices Advisory Committee (HICPAC) have established guidelines/recommendations for service animals in healthcare facilities. These recommendations may provide a practical shorthand practice guide for the practitioner.

-continued on page 9-

PUBLIC POLICY STATEMENT ON THE ADMISSION OF SERVICE ANIMALS TO PHYSICIANS' AND PODIATRISTS' OFFICES AND OTHER HEALTH CARE SETTINGS

-continued from page 8-

IV. Service Animals

A. Avoid providing facility access to nonhuman primates and reptiles as service animals.

B. Allow service animals to the facility in accordance with the Americans with Disabilities Act of 1990, unless the presence of the animal creates a direct threat to other persons or a fundamental alteration in the nature of the services.

C. When a decision must be made regarding a service animal's access to any particular area of the health-care facility, evaluate the service animal, patient, and health-care situation on a case-by-case basis to determine whether significant risk of harm exists and whether reasonable modifications in policies and procedures will mitigate this risk.

D. If a patient must be separated from his or her service animal while in the health-care facility 1) ascertain from the person what arrangements have been made for supervision or care of the animal during this period of separation; and 2) make appropriate arrangements to address the patient's needs in the absence of the service animal.

MMWR Recommendations and Reports. (2003). "Guidelines for Environmental Infection Control in Health-Care Facilities: Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC)." Retrieved August 12, 2009 from http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm. (*Citations omitted).*

Violations of the ADA may also be violations of the West Virginia Medical Practice Act, potentially subjecting the practitioner to discipline by the Board. The Board may discipline a physician or podiatrist for violating any provision of the Medical Practice Act or a rule or order of the board. W.Va. Code §30-3-14(c)(17). The legislative rules of the Board provide, in part, that the Board may discipline a physician or podiatrist upon satisfactory proof that the licensee has engaged in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public or any member thereof. 11 CSR 1A §12.1 (e). The licensee may also be disciplined by the Board if upon satisfactory proof it is demonstrated that the licensee: failed to perform any statutory duty or legal obligation placed upon a licensed physician or podiatrist, violated any law or lawfully promulgated rule or regulation of West Virginia, any other state, the Board, or the United States, which law or rule or regulation relates to or in part regulates the practice of medicine or podiatry, and or engaged in unprofessional conduct, including committing any act contrary to honesty, justice or good morals. 11 CSR 1A 12.1(j), (o), and (bb). Additionally, licensees may be disciplined for dishonorable, unethical or unprofessional conduct, including,

> Conduct which is calculated to bring or has the effect of bringing the medical or podiatric profession into disrepute, including, but not limited to, any departure from or failure to conform to the standards of acceptable and prevailing medical or podiatric practice within the state, and any departure from or failure to conform to the current principles of medical ethics of the AMA available from the AMA in Chicago, Illinois, or the principles of podiatric ethics of the APMA available from the APMA in Bethesda, Maryland. For the purposes of this subsection, actual injury to a patient need not be established.

11 CSR 1A 12.2(d).

Principle IX of the American Medical Association Principles of Medical Ethics provides that, "A physician shall support access to medical care for all people." American Medical Association Opinion 10.01 Fundamentals of the Patient-Physician Relationship, at subsection 3 provides, "The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs."

Physicians and podiatrists should be mindful of the needs of patients with disabilities, including those with service animals, so as to conform to the requirements of the law and the ethical standards of the profession.

NOTICE TO PHYSICIAN ASSISTANTS WITH LIMITED PRESCRIPTIVE WRITING PRIVILEGES

Now that 11 CSR 1B has been updated, Section 14 no longer requires that the drugs which individual physician assistants may prescribe be listed on the back of the prescription. 11 CSR 14.10 states that the Board of Medicine "shall provide the Board of Pharmacy with a list of physician assistants with limited prescriptive privileges along with the categories of drugs or drugs within a category that the physician assistant has been authorized to prescribe, and shall update the list within ten (10) days after additions or deletions are made." We are doing that.

Nevertheless, be aware that pharmacists may request you to supply in writing what you are authorized to prescribe. Be sure your list is accurate.

REMINDER FOR PHYSICIAN ASSISTANTS AND SUPERVISING PHYSICIANS

Both of you have responsibilities to inform the Board of Medicine in the event of termination of employment.

- 11 CSR 1B 9.2 states that the supervising physician shall notify the Board in writing of any termination of the employment of his or her physician assistant within 10 days of the termination.
- 11 CSR 1B 13.20 states that the physician assistant is required to notify the Board of any ending of his or her employment within 10 days. The physician assistant must provide the Board with his or her new address and telephone number of his or her residence, address and telephone number of employment and name of his or her supervising physician.
- 11 CSR 1B 13.21 states that the supervising physician is required to notify the Board of any ending of his or her supervision of a physician assistant within 10 days.

Despite these clear requirements, a number of you have not been adhering to them. Your failure to comply with 11 CSR 1B may create problems for you in the future with the Board. It is essential that you pay attention to what is required of you.

Ext #	Staff of the West Virginia Board of Medicine 304.558.2921	
227	**Robert C. Knittle, M.S.**	Executive Director
214	**Deborah Lewis Rodecker, J.D.**	General Counsel
215	**John A. Lohmann, J.D., M.B.A.**	Disciplinary Counsel
211	**Lori Blaney**	Paralegal
212	**M. Ellen Briggs**	Administrative Assistant to the Executive Director
224	**Wendy L. Greene**	Receptionist/Certification and Verification Coordinator
222	**Leslie A. Higginbotham**	Investigator, CMBI
210	**Charlotte A. Jewell**	Physician Assistant Coordinator
216	**Michael R. Lilly**	Information Systems Coordinator
213	**Charlotte Ann Pulliam**	Complaint Coordinator
220	**Deborah D. Scott**	Fiscal Officer
221	**Sheree J. Thompson**	Licensure Analyst

CHANGE OF ADDRESS FORM

NAME:_____ **LICENSE#:**_____
(Last) (First) (Middle) (Suffix)

By law, you must keep this office apprised of any and all address changes. **If not currently practicing, check here** □

PREFERRED MAILING ADDRESS (Required):
(This address is public information, except phone & email)

HOME ADDRESS:
☐ **Check here if same as preferred mailing address**

_____ Address 1 _____

_____ Address 2 _____

_____ City, State, Zip, County_____

_____ Phone _____

_____ Email _____

MAIN WORK ADDRESS:
☐ **Check here if same as preferred mailing address**

_____
Address 1

_____
Address 2

_____
City, State, Zip, County

_____
Phone Fax

_____
Email

Enter average weekly on call hours for **ALL** locations:_____

List **AVERAGE HOURS** worked per week (not on call) at this location:
Direct Patient Care:_____
Administration:_____
Formal Teaching:_____
Research:_____
Other Medical/Podiatric Activities:_____

SECOND WORK ADDRESS:

_____
Address 1

_____
Address 2

_____
City, State, Zip, County

_____
Phone

List **AVERAGE HOURS** worked per week (not on call) at this location:
Direct Patient Care:_____
Administration:_____
Formal Teaching:_____
Research:_____
Other Medical/Podiatric Activities:_____

THIRD WORK ADDRESS:

_____
Address 1

_____
Address 2

_____
City, State, Zip, County

_____
Phone

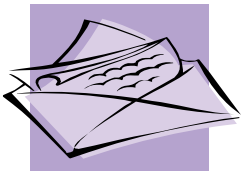
List **AVERAGE HOURS** worked per week (not on call) at this location:
Direct Patient Care:_____
Administration:_____
Formal Teaching:_____
Research:_____
Other Medical/Podiatric Activities:_____

Enter your self-designated primary and secondary SPECIALTY here: (M.D.'s and D.P.M.'s ONLY)
Primary Specialty: _____ Secondary Specialty: _____

LICENSEE'S ORIGINAL SIGNATURE:_____ DATE:_____

RETURN FORM TO: West Virginia Board of Medicine, 101 Dee Drive, Suite 103, Charleston, WV 25311

CHANGE OF ADDRESS INFORMATION



NOTE: There is a Change of Address Form located on Page 11 of this Newsletter. You may also visit the Board's website at www.wvbom.wv.gov for a Change of Address Form. By law, a licensee of the Board of Medicine must keep this office apprised of any and all address changes. The preferred mailing address of a licensee is the licensee's address of record, which is public information, with the exception of the telephone number and e-mail address.

WEST VIRGINIA BOARD OF MEDICINE 2009 MEETINGS

November 9

ALL BOARD MEETINGS BEGIN AT 9:00 A.M.

WV Board of Medicine

101 Dee Drive, Suite 103
Charleston, WV 25311

Phone: 304.558.2921
Fax: 304.558.2084

PRESORTED STANDARD
US POSTAGE PAID
CHARLESTON, WV 25301
PERMIT NO. 271

Place Mailing Address Label Here

www.wvbom.wv.gov
Watch for updates and changes.