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
www.wvbom.wv.gov

ATTENTION: Please Read Carefully Reinstatement Application Enclosed

You are eligible to file an application for reinstatement of your physician assistant license if your license expired (or otherwise terminated) less than one year before the date upon which your completed reinstatement application is received by the West Virginia Board of Medicine [the Board]. An application is complete when: (1) the Board receives your original Application for Reinstatement with complete responses and original signatures; (2) all necessary supporting documentation is received by the Board; and (3) all applicable fees are received by the Board. Applications and supporting documentation should be submitted to the Board office at the address provided hereinabove.

If you wish to be considered for the reinstatement of your physician assistant license, this reinstatement application must be completed by the physician assistant and forwarded to the Board Office, along with the following:

1. A nonrefundable application fee in the amount of $200.00, payable to the West Virginia Board of Medicine. The Board accepts the following forms of payment: business checks; personal checks; cashier's checks; credit cards; and money orders payable to the WV Board of Medicine; *If you are seeking temporary licensure approval pending action on your reinstatement application and submission of a complete practice agreement, you must also include an additional $50.00 for the temporary license fee*

2. Page 1- Please list all other states and/or jurisdictions where you currently hold or have ever held certification or licensure as a physician assistant.

3. Page 2- Any and all supporting documents and/or responses required in association with your responses to the Character and Fitness Questions;

4. Documentation of your current certification status from the National Commission on Certification of Physician Assistants (NCCPA). You may obtain this document from the NCCPA's Homepage, www.nccpa.net under verify credentials. *Wall certificates are not accepted as proof of your certification status.*

5. A National Practitioner Data Bank (NPDB) self-query report generated within thirty days of submission to the Board. You may request a self-query report by following the instructions on their website, http://www.npdb.hrsa.gov. Once the self-query report is generated please forward the unaltered PDF document as an email attachment to our Physician Assistant Coordinator, Amy.C.Callihan@wv.gov.

Applications are processed in order of receipt. The staff of the West Virginia Board of Medicine will make every effort to process your application as quickly as possible. To avoid delay in Reinstatement of your Physician Assistant License, carefully complete the application. Illegible, incomplete, and/or failure to provide all of the required information for this application will delay the processing of your application. Completion of the Reinstatement Application is the responsibility of the physician assistant. Do not delegate completion of this or any Board applications to office staff or any other person.

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 the Board to comply with the requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. If the Board should be required to make a report about one of its applicants or to 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 WWW.WVBOM.WV.GOV

APPLICATION FOR REINSTATEMENT OF 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: WV License #:

Last First Middle/Middle Initial Suffix

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

Date of Birth: Social Security Number:

E-mail address: Telephone #:

Preferred Mailing Address: Phone:

City: County: State: Zip:

Home Mailing Address: Phone:

City: County: State: Zip:

Are you certified by the National Commission on the Certification of Physician Assistants (NCCPA)? ☐ Yes ☐ No

If yes, Certificate No.: Expiration Date:
(Please submit documentation)
Month Day Year

Please list all other states and/or jurisdictions where you currently hold or have ever held certification or licensure as a physician assistant:

_____

_____

(The following questions must be answered pursuant to West Virginia Code §48-15-303.)

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 equal 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…….	☐	☐

Signature: _____ **Date:** _____

PROFESSIONAL PRACTICE, CHARACTER AND FITNESS QUESTIONS

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

At any time in the last two year 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? ……..... *Submit with your application certified copies of all court records related to any such charges, pleas, and/or convictions.*	☐	☐
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? ..... *Submit with your application certified copies of all court records related to any such charges, pleas, and/or convictions.*	☐	☐
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? ……..... *If "yes," you must have the facility submit directly to the Board all documentation related to your answer.*	☐	☐
7.	voluntarily resigned from any medical staff or voluntarily limited such staff privileges while under investigation by any health care 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 judgments or settlements arising from professional liability rendered or made against you, and if so, how many? ……..…. *For each judgment or settlement, provide the name(s) of the claimant(s), your insurer, whether you are reporting a judgment or a settlement, and the amount and date of each judgment or settlement.*	☐	☐
13.	failed the NCCPA examination or not maintained certification at any time? ……..… *If "yes," please provide a written explanation that includes the date(s) of failure and/or lapse in certification and cause.*	☐	☐
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? …… *(You may answer "no" if you are a participant in a written agreement with the West Virginia Medical Professionals Health Program, Inc.)* *If "yes," and you have gone through a rehabilitation program at any time, you MUST have that program furnish this Board a report of your treatment and progress.*	☐	☐
15.	had any interruption in your practice which might be 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? …..….	☐	☐

I have carefully read and understood all the questions included on each page of this application and have answered all 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 or misleading information in this application, I hereby agree and understand that any such act shall constitute good cause for licensure denial or the subsequent revocation of any license granted to me.

PHYSICIAN ASSISTANT'S SIGNATURE: _____ DATE:_____

ALL YES ANSWERS MUST BE ACCOMPANIED BY A WRITTEN EXPLANATION, SIGNED AND DATED BY YOU, EXPLAINING IN DETAILYOUR YES ANSWER(S). YOU MUST ALSO ENCLOSE OR CAUSE TO BE SUBMITTED ALL REQUESTED SUPPORTIVE DOCUMENTATION.

APPLICATION CERTIFICATION

I hereby certify that I have read the instructions explaining the reinstatement of licensure requirements for the State of West Virginia, and I understand what I have read and what I am required to produce for reinstatement of 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 reinstatement of 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 understand that if this application is not completed within one (1) year of the expiration date of my previous license, I must submit a new application for initial licensure to be considered for a new license in the future.

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

I understand that a license to practice as a physician assistant in West Virginia **does not** permit or authorize me to practice in this state until I have filed a proposed practice agreement with the Board and I have received written authorization from the Board to practice under physician supervision within the parameters of the approved practice agreement on file.

Physician Assistant's Original Signature:_____Date:_____