State of 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
INACTIVE TO ACTIVE APPLICATION

M - Z

Your license to practice medicine and surgery in the State of West Virginia is in an **INACTIVE** status.

If you wish to be considered for the activation of your medical license, you must: complete a change of status application; attach a letter accounting, to the satisfaction of the Board, for your period of inactivity; and attach all supporting written documentation of your successful completion of the required continuing medical education satisfactory to the Board during the period July 1, 2013, to June 30, 2015. **Please note that CME requirements for the reporting cycle have changed.** This change of status application may be downloaded from our website at www.wvbom.wv.gov.

Make your $400 check or money order payable to the West Virginia Board of Medicine.

By law, you **MUST** keep this office apprised of any and all of your address changes.

IMPORTANT

Because an original signature is required, applications are not accepted via facsimile or e-mail.

To **AVOID** delay in licensure activation, answer each question legibly and accurately. Review the entire application to verify that each answer is correct and complete. Illegible or incomplete applications **will be returned**. Applications received without the correct fee **will be returned**. We will be unable to finalize the processing of any application that is not complete.

Please do not delegate completion of the change of status application to any other person. Completion of the change in status application is the responsibility of the licensee.

Mail your completed application and fee to:

WEST VIRGINIA BOARD OF MEDICINE
101 Dee Drive, Suite 103
Charleston, WV 25311

 APPLICATION FOR CHANGE OF STATUS OF WEST VIRGINIA MEDICAL LICENSE FROM INACTIVE TO ACTIVE (M-Z)

(For the Period ending June 30, 2017)

Due to federal reporting requirements, this application requests your Social Security number. Disclosing your Social Security number is MANDATORY in order for the Board to comply with the requirements of the National Practitioner Data Bank. If the Board should be required to make a report about one of its applicants or licensees to the Data Dank, it must report that individual's Social Security number.

NAME OF PHYSICIAN: (Please type or print legibly) SOCIAL SECURITY NO: _____

_____

Last Name (including Jr., Sr., II, etc.) First Name Middle Name

LICENSE NO.: _____ DATE OF BIRTH: _____ SEX: _____

For the period of July 1, 2013 through June 30, 2015, please list each and every state and/or Canadian Province where you have been licensed, whether such license is currently active or not.

_____

_____

Please list all West Virginia HOSPITALS where you currently have admitting privileges If none, check here _____

a)_____

b)_____

c)_____

Please list each MEDICAL CORPORATION or MEDICAL PLLC for which you are a SHAREHOLDER, OWNER, or PARTNER If none, check here _____

a)_____

b)_____

c)_____

If not working as a medical doctor, please check here: _____

Enter the code for your SPECIALTY from the list on page Two:

Primary Specialty _____ Secondary Specialty _____

Workforce Planning Data:
In the 2014 regular session, the West Virginia Legislature passed a law requiring certain health related professional licensing boards, including the Board of Medicine, to request certain workforce planning data from its licensees. W. Va. Code §30-1-20 (2014). The following questions are to assist the Board in gathering the required information. The information collected will be supplied to the legislature in the aggregate to comply with the new law. If you are unsure of your anticipated retirement date, please provide your best estimate.

Anticipated Date of Retirement: _____

Percent of Time in Direct Services: _____ Percent of Time in Administration: _____

ACTIVE LICENSE $400.00 ____

BOARD USE ONLY

 APPLICATION FOR CHANGE OF STATUS OF WEST VIRGINIA MEDICAL LICENSE FROM INACTIVE TO ACTIVE (M-Z)
(For the Period ending June 30, 2017)

CODES FOR SELF-DESIGNATION OF PRACTICE SPECIALTY/ AREAS OF PRACTICE

AR Abdominal Radiology
AS Abdominal Surgery
ADM Addiction Medicine
ADP Addiction Psychiatry
AMF Adolescent Medicine (Family Medicine)
AMI Adolescent Medicine (Internal Medicine)
ADL Adolescent Medicine (Pediatrics)
ACA Adult Cardiothoracic Anesthesiology (Anesthesiology)
CHD Adult Congenital Heart Disease
OAR Adult Reconstructive Orthopedics
AHF Advanced Heart Failure & Transplant Cardiology (Internal Medicine)
AM Aerospace Medicine
A Allergy
AI Allergy & Immunology
PTH Anatomic/Clinical Pathology
ATP Anatomic Pathology
AN Anesthesiology
BBK Blood Banking/Transfusion Medicine
BIN Brain Injury Medicine (Neurology)
BIP Brain Injury Medicine (Physical Medicine & Rehabilitation)
CTR Cardiothoracic Radiology
CD Cardiovascular Disease
PCH Chemical Pathology
CAP Child Abuse Pediatrics
CHP Child and Adolescent Psychiatry
CHN Child Neurology
CBG Clinical Biochemical Genetics
ICE Clinical Cardiac Electrophysiology
CCG Clinical Cytogenetics
CG Clinical Genetics
CIP Clinical Informatics (Pathology)
CIM Clinical Informatics (Preventive Medicine)
DDL Clinical and Laboratory Dermatological Immunology
ILI Clinical and Laboratory Immunology (Internal Medicine)
PLI Clinical and Laboratory Immunology (Pediatrics)
ALI Clinical and Laboratory Immunology (Allergy & Immunology)
CMG Clinical Molecular Genetics
CN Clinical Neurophysiology
CLP Clinical Pathology
PA Clinical Pharmacology
CRS Colon & Rectal Surgery
CHS Congenital Cardiac Surgery (Thoracic Surgery)
CS Cosmetic Surgery
CFS Craniofacial Surgery
CCA Critical Care Medicine (Anesthesiology)
CCE Critical Care Medicine (Emergency Medicine)
CCM Critical Care Medicine (Internal Medicine)
OCC Critical Care Medicine (Obstetrics & Gynecology)
ASO Complex General Surgical Oncology (Surgery)
PCP Cytopathology
D Dermatology
DMP Dermatopathology
DS Dermatologic Surgery
DBP Developmental-Behavioral Pediatrics
DIA Diabetes
DR Diagnostic Radiology
EMS Emergency Medical Services
EM Emergency Medicine
END Endocrinology, Diabetes and Metabolism
ESN Endovascular Surgical Neuroradiology (Radiology)
ES Endovascular Surgical Neuroradiology (Neurological Surgery)
ENR Endovascular Surgical Neuroradiology (Neurology)
EP Epidemiology
EPL Epilepsy
FPS Facial Plastic Surgery
FM Family Medicine
UPR Female Pelvic Medicine (Urology)
FPR Female Pelvic Medicine & Reconstructive Surgery (Obstetrics & Gynecology)
FOP Forensic Pathology
PFP Forensic Psychiatry
GE Gastroenterology
GP General Practice
GS General Surgery
FPG Geriatric Medicine (Family Medicine)
IMG Geriatric Medicine (Internal Medicine)
PYG Geriatric Psychiatry
GYN Gynecology
GO Gynecological Oncology
HS Hand Surgery
HNS Head & Neck Surgery
HEM Hematology (Internal Medicine)
HMP Hematology (Pathology)
HO Hematology/Oncology
HEP Hepatology
HPM Hospice & Palliative Medicine
HPA Hospice & Palliative Medicine (Anesthesiology)
HPE Hospice & Palliative Medicine (Emergency Medicine)
HPF Hospice & Palliative Medicine (Family Medicine)
HPI Hospice & Palliative Medicine (Internal Medicine)
HPO Hospice & Palliative Medicine (Obstetrics & Gynecology)
HPP Hospice & Palliative Medicine (Pediatrics)
HPR Hospice & Palliative Medicine (Physical Medicine & Rehabilitation)
HPN Hospice & Palliative Medicine (Psychiatry & Neurology)
HPD Hospice & Palliative Medicine (Radiology)
HPS Hospice & Palliative Medicine (Surgery)
HOS Hospitalist
IG Immunology
PIP Immunopatholgy
ID Infectious Disease
IM Internal Medicine
MPD Internal Medicine/Pediatrics
IC Interventional Cardiology
LM Legal Medicine
MFM Maternal & Fetal Medicine
MBG Medical Biochemical Genetics
MG Medical Genetics
MDM Medical Management
MM Medical Microbiology
ON Medical Oncology
MDP Medical Physics
ETX Medical Toxicology (Emergency Medicine)
PDT Medical Toxicology (Pediatrics)
PTX Medical Toxicology (Preventive Medicine)
MGG Molecular Genetic Pathology (Medical Genetics)
MGP Molecular Genetic Pathology (Pathology)
OMO Musculoskeletal Oncology
MSR Musculoskeletal Radiology
NPM Neonatal-Perinatal Medicine
NEP Nephrology
NDP Neurodevelopmental Disabilities (Pediatrics)
NDN Neurodevelopmental Disabilities (Psychiatry & Neurology)
N Neurology
NS Neurological Surgery
NMN Neuromuscular Medicine (Neurology)
NMP Neuromuscular Medicine (Physical Medicine & Rehabilitation)
NP Neuropathology
RNR Neuroradiology
NUP Neuropsychiatry
NO Neurotology (Otolaryngology)
NC Nuclear Cardiology
NM Nuclear Medicine
NR Nuclear Radiology
NTR Nutrition
OAN Obstetric Anesthesiology (Anesthesiology)
OBS Obstetrics
OBG Obstetrics & Gynecology
OM Occupational Medicine
OPR Ophthalmic Plastic and Reconstructive Surgery (Ophthalmology)
OPH Ophthalmology
OMF Oral & Maxillofacial Surgery
ORS Orthopedic Surgery
OSS Orthopedic Surgery of the Spine
OTR Orthopedic Trauma
OMM Osteopathic Manipulative Medicine
OFA Foot and Ankle, Orthopedics
OTO Otolaryngology
PME Pain Management
PMM Pain Medicine
APM Pain Medicine (Anesthesiology)
PMN Pain Medicine (Neurology)
PMP Pain Medicine (Physical Medicine & Rehabilitation)
PPN Pain Medicine (Psychiatry)
PLM Palliative Medicine
PDA Pediatric Allergy
PAN Pediatric Anesthesiology (Anesthesiology)
PDC Pediatric Cardiology
PCS Pediatric Cardiothoracic Surgery
CCP Pediatric Critical Care Medicine
PDD Pediatric Dermatology
PE Pediatric Emergency Medicine (Emergency Medicine)
PEM Pediatric Emergency Medicine (Pediatrics)
PDE Pediatric Endocrinology
PG Pediatric Gastroenterology
PHO Pediatric Hematology/Oncology
PDI Pediatric Infectious Disease
PN Pediatric Nephrology
PO Pediatric Ophthalmology
OP Pediatric Orthopedics
PDO Pediatric Otolaryngology
PP Pediatric Pathology
PDP Pediatric Pulmonology
PDR Pediatric Radiology
RPM Pediatric Rehabilitation Medicine
PPR Pediatric Rheumatology
NSP Pediatric Surgery (Neurology)
PDS PediatricSurgery(Surgery)
PTP Pediatric Transplant Hepatology (Pediatrics)
UP Pediatric Urology
PD Pediatrics
PHM Pharmaceutical Medicine
PHL Phlebology
PM Physical Medicine & Rehabilitation
PS Plastic Surgery
PSH Plastic Surgery within the Head & Neck
PSO Plastic Surgery within the Head & Neck (Otolaryngology)
PSP Plastic Surgery within the Head & Neck (Plastic Surgery)
GPM General Preventive Medicine
PRD Procedural Dermatology
PRO Proctology
P Psychiatry
PYA Psychoanalysis
PYM Psychosomatic Medicine
PHP Public Health and General Preventive Medicine
PCC Pulmonary Critical Care Medicine
PUD Pulmonary Disease
RO Radiation Oncology
RP Radiological Physics
R Radiology
REN Reproductive Endocrinology and Infertility
RHU Rheumatology
SP Selective Pathology
SME Sleep Medicine
SMA Sleep Medicine (Anesthesiology)
SMI Sleep Medicine (Internal Medicine)
SMO Sleep Medicine (Otolaryngology)
SMP Sleep Medicine (Pediatrics)
SMN Sleep Medicine (Psychiatry & Neurology)
SCI Spinal Cord Injury Medicine
ESM Sports Medicine (Emergency Medicine)
FSM Sports Medicine (Family Medicine)
ISM Sports Medicine (Internal Medicine)
OSM Sports Medicine (Orthopedic Surgery)
PSM Sports Medicine (Pediatrics)
PRS Sports Medicine (Physical Medicine & Rehabilitation)
CCS Surgical Critical Care (Surgery)
HSO Surgery of the Hand (Orthopedics)
HSP Surgery of the Hand (Plastic Surgery)
HSS Surgery of the Hand (Surgery)
SO Surgical Oncology
TS Thoracic Surgery
TRS Trauma Surgery
THP Transplant Hepatology (Internal (Medicine)
TTS Transplant Surgery
UME Undersea & Hyperbaric Medicine (Emergency Medicine)
UM Undersea & Hyperbaric Medicine (Preventive Medicine)
UCM Urgent Care Medicine
U Urology
VIR Vascular and Interventional Radiology
VM Vascular Medicine
VN Vascular Neurology
VS Vascular Surgery

In addition to the above, the following specialty designations are also used:

OS Other (i.e., a specialty other than those appearing above)
US Unspecified

 Physician's Name: _____

An e-mail address is required to ensure that you receive timely communications and updates from the Board. Only your primary work address will be available on the WVBOM website. Your e-mail address is not available on the WVBOM website.

E-MAIL ADDRESS: _____

HOME ADDRESS:

_____
Street Address **City** **County**

_____**Telephone:**_____**Mobile Phone:**_____
State **Zip**

PRIMARY WORK ADDRESS: _____
Business Name

_____**Telephone:** _____
Street Address

_____
City **County** **State** **Zip**

WORK ADDRESS #2: _____
Business Name

_____**Telephone:**_____
Street Address

_____
City **County** **State** **Zip**

WORK ADDRESS #3: _____
Business Name

_____**Telephone:**_____
Street Address

_____
City **County** **State** **Zip**

Your primary work address is listed on the WVBOM website. Your preferred mailing address is the primary address used by the WVBOM to contact you. The WVBOM may also seek to contact you at any e-mail address you provide.

Please designate the address you want listed as your preferred mailing address:

_____ home address **_____ primary work location** **_____ work location #_____(i.e. 2, 3, etc.)**

 Physician's Name: _____

Please be advised that the following certification is a mandatory component of this application. State law requires that you be notified 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." West Virginia Code §48-15-303.

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 ORIGINAL SIGNATURE:_____ DATE:_____

CERTIFICATION OF CONTINUING MEDICAL EDUCATION COMPLIANCE

All responses shall be for the period July 1, 2013 to June 30, 2015.

If you have questions, please contact the Board office at 304 558 2921.

YOU MUST SEND CERTIFICATES WITH THIS APPLICATION.

Mandatory drug diversion training and best practices prescribing of controlled substances CME

Please check the box that is applicable to you. ***You must select one.***

☐ I completed a minimum of three (3) hours of drug diversion training and best practice prescribing of controlled substances through a course which has been approved by the West Virginia Board of Medicine.

OR

☐ I attest that during the period of July 1, 2013, to June 30, 2015, I did not prescribe, administer, or dispense **any controlled substances whatsoever.** I therefore request that the Board waive this CME requirement.

In addition to meeting my mandatory drug diversion training and best practice prescribing of controlled substances CME obligation in the manner indicated above:

Please check the statement that describes how you satisfied your CME obligation for the identified reporting period.

_____ I have successfully completed a minimum of fifty (50) hours of continuing medical education satisfactory to the Board, as described in 11 CSR 6 3.1 and 11 CSR 6 3.2, including the three hours of mandatory drug diversion training and best practices prescribing of controlled substances CME unless I have requested a waiver of that requirement hereinabove.

OR

_____ I am ABMS board certified, and have attached documentation of successful involvement in maintenance of certification from said ABMS member board, as described in 11 CSR 6 3.2.3.

I understand that any license renewed on the basis of this application is wholly contingent upon on the truth of the information I provide. In the event that I furnish any false or misleading information in this application, including with respect to my Certification of CME Compliance, such act constitutes good cause for the revocation of my license to practice medicine in the State of West Virginia.

PHYSICIAN'S ORIGINAL SIGNATURE: _____ DATE: _____

You may be audited! A sample number of physicians will be audited for the purpose of documenting continuing medical education hours. If audited, you will be required to provide proof by submitting acceptable written confirmation of your completion of required continuing medical education. If you have requested a waiver of the 3 hour drug diversion training CME, part of your audit may require independent verification through the Controlled Substance Monitoring Program that you have not prescribed any controlled substances during the requisite period.

 Physician's Name: _____

PROFESSIONAL PRACTICE QUESTIONS

DURING THE PERIOD OF JULY 1, 2013 TO PRESENT 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 the practice of medicine, 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 license to practice by a medical board, or had your license to practice suspended, revoked or subjected to any kind of disciplinary action, including censure, reprimand or probation by a medical board, and/or are any disciplinary actions pending against you?.....	_____	_____
5.	voluntarily surrendered (not expired) to a medical board or limited your medical license with a medical board?.....	_____	_____
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? *If "yes," you must have the facility submit directly to the Board by the renewal deadline 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 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?_____ *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.	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 voluntary agreement with the West Virginia Medical Professionals Health Program, Inc., the West Virginia Board of Medicine designated physician health program.) *If you answer yes and have gone through a rehabilitation program during the time frame designated above, you MUST have that program furnish this Board a report of your treatment and progress by the renewal deadline*.....	_____	_____
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?.....	_____	_____

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

****

By placing my signature herein below, I attest that I have carefully read the questions in this application and have answered them completely. All of my answers and statements made herein are true and correct. I understand that any license renewed on the basis of this application is based upon the truthfulness and completeness of the statements I have made herein. I understand that furnishing false information in connection with this application constitutes good cause for the revocation of my license to practice medicine in West Virginia

PHYSICIAN'S ORIGINAL SIGNATURE:_____**DATE:**_____