WVBOM Photo Affidavit and Authorization for Release of Information

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

First: **Middle:** **Last:** **Suffix:**

Profession Type: ☐ **MD** ☐ **DPM** ☐ **PA**

Identifying Characteristics

Sex: ☐ **Male** ☐ **Female**

Height (ft.in): _____

Weight (lbs.): _____

Hair Color: _____

Eye Color: _____

Identifying Marks: _____

_____

Date attached photo was taken: _____
(mm/dd/yyyy)

Applicant Photograph

Securely tape or glue a front-view 2" x 2" passport-type color photo of yourself in this square. Photo must be clear, accurately depict the applicant, and have been taken within 12 months of the date the Board receives this form.

PHOTO MUST BE ATTACHED PRIOR TO NOTARIZATION

Authorization for Release of Application Status

The person(s) listed below have my permission to check on the status of my application for a West Virginia license. I understand that I may revoke this authorization, in writing, at any time during the application process. (If you do not want to authorize anyone else to receive status updates, please leave this section blank.)

_____ _____
Type or print name clearly *Type or print name clearly*

Applicant's Signature: _____ **Date:** _____
(mm/dd/yyyy)

Notarized Affidavit and Authorization for Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Licensure Application I submitted to this Board and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

Continued on page 2

Continued from page 1

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

_____

Applicant's printed legal name

_____

Applicant's signature (must be signed in the presence of a notary)

_____

Date (must be dated in the presence of a notary and correspond to date of notarization)

Notary

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

State of _____ County of _____ The statements

on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20_____.
Day *Month* *Year*

Notary Public Signature: _____ [Notary Seal]

My Notary Commission Expires: _____

Practice Information

Do you have proposed practice plans for West Virginia? YES ☐ NO ☐
If yes, please describe your practice plans and proposed practice location:

Plans: _____ Location _____

Do your practice plans involve practice via telehealth? YES ☐ NO ☐

Are you currently working as a provider? YES ☐ NO ☐
If no, how long have you been absent from clinical practice? _____

FOR MDs AND DPMs ONLY

List your area of practice specialty: _____ Are you board certified? YES ☐ NO ☐

If yes, please list your certifying board: _____

Mail original form to:
West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, WV 25311