



## State of West Virginia

### ***Board of Medicine***

101 Dee Drive, Suite 103

Charleston, WV 25311

Telephone 304.558.2921

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[www.wvbom.wv.gov](http://www.wvbom.wv.gov)

### **ATTENTION: PLEASE READ CAREFULLY** **REINSTATEMENT APPLICATION**

Your license to practice medicine and surgery in the State of West Virginia is in an **EXPIRED** status effective June 30, 2016, at 11:59 p.m. An expired license is not a valid license.

If you wish to be considered for the reinstatement of your medical license, you must complete a reinstatement application and attach all supporting written documentation of your successful completion of required continuing medical education satisfactory to the Board during the period July 1, 2014, to present.

If you seek an **ACTIVE** status license to practice medicine in West Virginia between now and July 1, 2017, you must complete the reinstatement application selecting **ACTIVE STATUS** and return it to this office with the total fee of \$600 (\$400 active renewal fee and \$200 reinstatement fee). If you seek an **INACTIVE** status license to practice medicine in West Virginia, you may complete the reinstatement application selecting **INACTIVE STATUS** and return it to this office with the total fee of \$225 (\$150 inactive renewal fee and \$75 reinstatement fee). Make your check or money order payable to the West Virginia Board of Medicine. **INACTIVE STATUS** means that you may not practice any type of medicine in West Virginia. Any practice of medicine whatsoever, including the writing of any prescriptions, is **ACTIVE PRACTICE**. After July 1, 2017, if you wish to be licensed to practice medicine and surgery in West Virginia, you must apply for a new license.

Continuing medical education is required whether your registration is in active or inactive status. As part of the reinstatement application you must complete, sign and date the Continuing Medical Education Certification. **Please note that your CME requirements for this reporting cycle have changed.**

By law, you **MUST** keep this office apprised of any and all address changes that occur during your registration period.

### **IMPORTANT**

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

To **AVOID** delay in licensure reinstatement, or continued **EXPIRATION** of your medical license, 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 reinstatement application to any other person. Completion of the reinstatement application is the responsibility of the licensee.

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Mail your completed application,  
evidence of CME completed and fee to:

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

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 Bank, 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, 2014 through June 30, 2016, 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: \_\_\_\_\_

Indicate desired status for renewing your license (only one)	
ACTIVE LICENSE	\$600.00 _____
INACTIVE LICENSE	\$225.00 _____

_____ <b>BOARD USE ONLY</b> _____
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## CODES FOR SELF-DESIGNATION OF PRACTICE SPECIALTY/ AREAS OF PRACTICE

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

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

Your e-mail address is not available on the WVBOM website. 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, however, your contact information may be subject to disclosure if a request for this information is received by the Board.

E-MAIL ADDRESS: \_\_\_\_\_

HOME ADDRESS:

\_\_\_\_\_

Street Address	City	County
State	Zip	Telephone: _____
		Mobile Phone: _____

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.)

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:

- |   | <u>YES</u> | <u>NO</u> |
|---|------------|-----------|
| 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, 2014 to present.

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, 2014, to present, 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.

### PROFESSIONAL PRACTICE QUESTIONS

DURING THE PERIOD OF JULY 1, 2014, TO PRESENT HAVE YOU, IN ANY JURISDICTION, FOR ANY REASON:

	<u>YES</u>	<u>NO</u>
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? <u>Submit with your application certified copies of all court records related to any such charges, pleas and/or convictions.</u> .....	_____	_____
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? <u>Submit with your application certified copies of all court records related to any such charges, pleas and/or convictions.</u>	_____	_____
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? <u>If "yes," you must have the facility submit directly to the Board by the renewal deadline all documentation related to your answer.</u> ....	_____	_____
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? _____ <u>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</u> .....	_____	_____
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.) <u>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.</u> .....	_____	_____
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: \_\_\_\_\_