West Virginia Board of Medicine

Application Form to Obtain a Certificate of Authorization for an Out-of-State Medical Corporation to Practice in the State of West Virginia

Today's Date: ________________________

Name of Corporation:

____

Address of Record in State of Incorporation:

____

____

(City) (State) (Zip Code)

Telephone Number: (____)_____________**Fax Number** (____)_____________

FEIN: _______________________ **Email:** __________________@__________

Proposed West Virginia Location: _____________________________________

____

(City) (State) (Zip Code) (County)

Telephone Number: (____)_____________Fax Number (____)_____________

Preferred Mailing Address:

____

____

(City) (State) (Zip Code)

List West Virginia Designated Corporate Shareholder (Must be MD, DPM or DO with valid WV license)

Name: ____________________________________, MD, DPM or DO (circle one)

Address:____

____
(City) (State) (Zip Code)

WV License #: ___________________

List All Other Shareholders (All must be licensed MDs, DPMs, DOs)

Name:_________________________

Address:_______________________

____

State Where Licensed and License #:

____

____
(Signature)

Name:____________________________

Address:__________________________

____

State Where Licensed and License #:

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(Signature)

Name:_________________________

Address:_______________________

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State Where Licensed and License #:

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(Signature)

Name:____________________________

Address:_______________________

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State Where Licensed and License #:

____

____
(Signature

(If needed, additional shareholders may be listed on the reverse of this form)

CERTIFICATION

On behalf of the applicant corporation, I hereby certify that:

(1) the information provided in this application is true and correct;

(2) each shareholder in the applicant corporation is a licensed physician and the required information regarding each shareholder has been provided with this application; and

(3) the applicant corporation has received authorization from the appropriate authorities as a medical or podiatry corporation or professional corporation in its state of incorporation and is currently in good standing with that authority.

I further certify that should this application be granted, the applicant corporation understands that the corporate ownership must include a licensed West Virginia physician or podiatrist at all times for the Certificate of Authorization to engage in the practice of medicine, surgery or podiatry to remain valid.

____Date:_______________
President's Signature (must be MD, DPM or DO)

____Date:_______________
West Virginia Designated Corporate Representative
Signature

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BOARD USE ONLY