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

ATTENTION: PLEASE READ CAREFULLY
REINSTATEMENT APPLICATION INSTRUCTIONS

Your license to practice podiatric medicine and surgery in the State of West Virginia is in an **EXPIRED** status effective June 30, 2017, at 11:59 p.m. EDST. An expired license is not a valid license. You are eligible to request reinstatement of your expired license until June 30, 2018. After July 1, 2018, to seek relicensure, you must apply for a new license.

IMPORTANT INFORMATION FOR ALL APPLICANTS

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

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 podiatric 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 applicant.

Instructions for reinstatement applicants seeking an ACTIVE status license:

1. 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). Make your check or money order payable to the West Virginia Board of Medicine.

2. Complete, sign and date the Continuing Medical Education Certification and provide documentation supporting successful completion of the required CME

3. If you have prescribed or dispensed Schedule II, III or IV controlled substances pursuant to a West Virginia medical license since July 1, 2015, and have been registered with the West Virginia Controlled Substances Monitoring Database, you will be required to submit a copy of your certificate of registration.

Instructions for reinstatement applicants seeking an INACTIVE status license:

1. INACTIVE STATUS means that you may not practice podiatric of medicine in West Virginia. Any practice of podiatry whatsoever, including the writing of any prescriptions, is ACTIVE PRACTICE. Continuing podiatric education is required whether your registration is in active or inactive status.

2. Complete the reinstatement application selecting INACTIVE STATUS and return it to this office with the total fee of $225 ($150 active renewal fee and $75 reinstatement fee). Make your check or money order payable to the West Virginia Board of Medicine.

3. Complete, sign and date the Continuing Medical Education Certification and provide documentation supporting successful completion of the required CME.

4. If you have prescribed or dispensed Schedule II, III or IV controlled substances pursuant to a West Virginia medical license since July 1, 2015, and have been registered with the West Virginia Controlled Substances Monitoring Database, you will be required to submit a copy of your certificate of registration.

Mail your completed application and fee to:

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

 REINSTATEMENT APPLICATION FOR LICENSE TO PRACTICE PODIATRIC MEDICINE AND SURGERY IN WEST VIRGINIA
(For the Period ending June 30, 2018)

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 federal 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.

Please type or print legibly.

NAME OF PODIATRIC PHYSICIAN: **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, 2015 through the present, 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 PODIATRIC MEDICAL CORPORATION or PODIATRIC PLLC for which you are a SHAREHOLDER, OWNER, or PARTNER If none, check here _____

a)_____

b)_____

If not working as a podiatric physician, please check here: _____

Workforce Planning Data:

W. Va. Code §30-1-20 (2014) requires the Board of Medicine to collect the following data. 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: _____

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

Primary Specialty _____ **Secondary Specialty _____**

Indicate desired status for renewing your license (only one)

ACTIVE LICENSE $600.00 ____

INACTIVE LICENSE $225.00 ____

_____BOARD USE ONLY_____

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

FOR Foot Orthopedics, or Biomechanics

GP General Practice

PD Podiatric Dermatology

PGR Podogeriatrics

PPD Podopediatrics

ROE Roentgenology

S Surgery

OS Other Specialty

NS No Specialty

 Podiatric Physician's Printed Name: _____

REINSTATEMENT APPLICATON FOR LICENSE TO PRACTICE PODIATRIC MEDICINE & SURGERY IN WEST VIRGINIA
(For the Period ending June 30, 2018)

The Board may seek to contact you at any e-mail address you provide.

E-MAIL ADDRESS: _____

HOME ADDRESS (This is your principal place of residence and is a physical address. Please do not use a P O Box as your home address, however, it may be your preferred contact address):

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

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

PREFERRED CONTACT ADDRESS: (**Preferred contact information is the contact information that the Board will use to contact you. Please be advised that this information may be subject to release pursuant to a public records request.)**

_____
Business Name (if applicable)

_____**Telephone: _____**
Street Address

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

PRIMARY WORK ADDRESS: (Only your primary work address is listed on the WVBOM website.)

_____
Business Name

_____**Telephone:**_____
Street Address

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

WORK ADDRESS #2:

_____
Business Name

_____**Telephone:**_____
Street Address

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

REINSTATEMENT APPLICATON FOR LICENSE TO PRACTICE PODIATRIC MEDICINE & SURGERY IN WEST VIRGINIA
(For the Period ending June 30, 2018)

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:_____

If you answered "yes" to any of the above question, and if further information is necessary, you will be notified.

CERTIFICATION OF CONTINUING EDUCATION COMPLIANCE

All responses shall be for the period of July 1, 2015 to present.

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

YOU MUST SEND CPE CERTIFICATES WITH THIS APPLICATION.

Mandatory drug diversion training and best practices prescribing of controlled substances CME
A list of Board approved training can be found at https://wvbom.wv.gov/Best_Practice_Prescribin.asp .

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 though a course which has been approved by the West Virginia Board of Medicine.

OR

☐ I attest that during the period of July 1, 2015 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 CPE obligation in the manner indicated above:

I certify that between July 1, 2015 and the date of this application, I have successfully completed a minimum of fifty (50) hours of continuing podiatric education satisfactory to the Board, as described in 11 CSR 6.3.4 and 11 CSR 6.3.5., 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.

PODIATRIC PHYSICIAN'S ORIGINAL SIGNATURE: _____ DATE: _____

You may be audited! 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.

 Podiatric Physician's Printed Name: _____

REINSTATEMENT APPLICATON FOR LICENSE TO PRACTICE PODIATRIC MEDICINE & SURGERY IN WEST VIRGINIA

(For the Period ending June 30, 2018)

CHARACTER & FITNESS QUESTIONS

DURING THE PERIOD OF JULY 1, 2015, 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 podiatric 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/podiatric 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/podiatric board, and/or are any disciplinary actions pending against you?.....	_____	_____
5.	voluntarily surrendered (not expired) to a medical/podiatric board or limited your podiatric license with a medical/podiatric 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 podiatry examination?.....	_____	_____
9.	been denied a license to practice podiatry?.....	_____	_____
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 using the form provided***.....	_____	_____
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 podiatry which might reasonably be expected by an objective person to currently impair your ability to carry out the duties and responsibilities of the podiatric profession in a manner consistent with standards of conduct for the podiatric 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 podiatric profession in a manner consistent with the standards of conduct for the podiatric profession?.....	_____	_____

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.

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

PROOF OF CONTROLLED SUBSTANCE MONITORING PROGRAM REGISTRATION

Effective June 10, 2016, all podiatric physicians who prescribe or dispense Schedule II, III and/or IV controlled substances are required to obtain and maintain registration with the West Virginia Controlled Substance Monitoring Program (CSMP). This is not the same as a DEA registration, and is obtained through the West Virginia Board of Pharmacy at https://www.csapp.wv.gov.

Please select the option that is applicable to you:

☐ Since July 1, 2015 I have not prescribed Schedule II, III and/or IV controlled substances pursuant to my West Virginia podiatric license, and I am not registered with the CSMP.

☐ I am currently registered with the CSMP, and I have enclosed a copy of my CSMP registration certificate.

☐ I am not currently registered with the CSMP, but I understand that if I intend to prescribe or dispense any Schedule II, III and/or IV controlled substances pursuant to my West Virginia medical license, I must be registered to access the WVCSMP within thirty days of receipt of any podiatric license issued pursuant to this application.

PODIATRIC PHYSICIAN'S
ORIGINAL SIGNATURE:_____ DATE:_____

CERTIFICATION

By AFFIXING MY INITIALS next to the following statements, I certify that:

_____ I understand that I am required to personally complete this application, and I am solely responsible for the accuracy and completeness of the information provided, including all information regarding my practice since July 1, 2015, and my certification of successful completion of all required continuing podiatric education.

_____ I have carefully read and understood all the questions included on each page of this reinstatement 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 reinstatement application is based on the truth of the statements contained herein. Should I furnish false or misleading information in this reinstatement application, I hereby agree and understand that any such act shall constitute good cause for disciplinary action and/or the subsequent revocation of my license.

_____ I understand that regardless of the date of my signatures, all statements in this reinstatement application relate to the entire period of July 1, 2015 to present. If, after I provide my signature and prior to reinstatement of my license, any answer should change for any reason, I have a duty to notify the Board and amend my reinstatement application.

PODIATRIC PHYSICIAN'S
ORIGINAL SIGNATURE: _____ DATE: _____