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

PHYSICIAN ASSISTANT LICENSURE REQUIREMENTS
FOR THE STATE OF WEST VIRGINIA

All applicants for physician assistant licensure in the State of West Virginia shall provide evidence of the following:

1. Proof of graduation from an approved program of instruction in primary health care or surgery;

2. Successful completion of the National Certification Examination for Primary Care Physician Assistants and evidence of current certification;

3. All Professional Practice, Character and Fitness requirements to practice as a physician assistant are met; and

4. Proof of attained baccalaureate or master's degree, as evidenced by a copy of the diploma.

We do accept information from the Federation Credentials Verification Service (FCVS).

There are no exceptions to the above requirements except, at the discretion of the Board, a physician assistant may be licensed if he or she meets either of the following standards:

1. He or she is a graduate of an approved program of instruction in primary health care or surgery prior to July 1, 1994, and has passed the certifying examination for a physician assistant administered by the National Commission on Certification of Physician Assistants (NCCPA) and has maintained certification by that commission so as to be currently certified; **or**
2. He or she had been certified by the board as a physician assistant then classified as "Type B", prior to July 1, 1983.

Additional information and copies of the Physician Assistant law and Board of Medicine Rules may be obtained from the Board's website at www.wvbom.wv.gov. Inquiries regarding these requirements may also be made to the staff of the West Virginia Board of Medicine.

All licenses expire March 31 every odd numbered year. If renewal is not received by this date, any license granted to you pursuant to this application will expire.

INSTRUCTIONS FOR COMPLETING APPLICATION FOR PHYSICIAN ASSISTANT LICENSURE

Page 1: Complete in full with recent photograph attached. The name you enter must exactly match the name on your diploma, or documentation of formal name change must be submitted.

Page 2-3: Answer all questions.

Page 4: Complete in full and return with the application. List all states in which you are now or have ever been certified or licensed as a physician assistant, regardless of the status of that license. List all employment since graduation from physician assistant school.

Page 5: Complete this page in the presence of a Notary Public and return it with the application.

Page 6: **You must send this page to your college for completion.** The school must return it directly to the WV Board of Medicine.

Page 7: This page is to be completed by a physician or podiatrist who is licensed in the United States. The Affiant must know you and must not be related to you by blood or marriage. The form must be notarized. **This is not to be completed by the applicant and cannot be completed by your proposed or potential supervising physician.**

Page 8: This page is to be sent to each state and jurisdiction where you now hold or have every held certification or licensure as a physician assistant, regardless of the status of that license. Please complete only the top section of this page. The state licensing Board will complete the rest of the information and should return this form directly to the Board. You may make copies of this page as needed.

THE FOLLOWING MUST ALSO BE SUBMITTED WITH THIS APPLICATION:

1. A nonrefundable application fee in the amount of $250.00, payable to the West Virginia Board of Medicine. The Board accepts the following forms of payment: business checks; personal checks; cashier's checks; credit cards; and money orders payable to the WV Board of Medicine;

2. A legible copy of your physician assistant diploma;

3. Documentation of your current certification status from the National Commission on Certification of Physician Assistants (NCCPA); and

4. A National Practitioner Data Bank (NPDB) self-query report generated within thirty days of submission to the Board. Please contact the NPDB at 1-800-767-6732 to request the "Practitioner Request for Information Disclosure" self-query forms. You may find these forms on their website at http://www.npdb.hrsa.gov. Once you receive the forms, complete them in their entirety, sign in the presence of a notary, and forward to the NPDB. The NPDB will generate an email and, upon request, a paper report will be sent to you. You must submit the original unopened report (not photocopies) or forward the e-mail unaltered to our Physician Assistant Licensure Analyst at Diane.M.Callison@wv.gov.

ADDITIONAL INSTRUCTIONS

BOARD MEETINGS:

Board meetings are held every other month, beginning in January. When your application is processed, you will receive a letter notifying you of what documentation is outstanding. For your application to be considered by the Board, the Board must be in receipt of your fully completed application fifteen days in advance of the scheduled Board meeting. If you answer "yes" to any of the Personal Data questions on Page (2) or any of the Professional Practice, Character and Fitness questions on Page (3) of the application, you may be required to appear before the Physician Assistant Committee to discuss your application and you may be ineligible for a temporary license.

TEMPORARY APPROVAL:

Once your completed application is reviewed by this office and upon completion of this review, you may request a temporary license. This request must be in writing and accompanied by a $50.00 temporary license fee. This fee is non-refundable.

NOTICE

In order to comply with federal law, the West Virginia Board of Medicine is obligated to inform each applicant or licensee from whom it requests a Social Security Number that disclosing such number is MANDATORY in order for this Board to comply with the requirements of the federal National Practitioner Data Bank. If this Board should be required to make a report about one of its applicants or licensees to this data bank, it must report that individual's Social Security Number.

WEST VIRGINIA BOARD OF MEDICINE
101 DEE DRIVE, SUITE 103, CHARLESTON, WEST VIRGINIA 25311,
(304) 558-2921 WWW.WVBOM.WV.GOV

APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

Please type or print clearly. Do not leave any sections blank. If not applicable, write N/A.

Applicant's Name: _____
(Last) (First) (Middle) (Suffix)

Alternate Name (including maiden name): _____
(Last) (First) (Middle) (Suffix)

Email address: _____ Social Security Number: ___ - ___ - ___

Date of Birth: ___ / ___ / ___
(MM) (DD) (YY)

Preferred Mailing Address: _____ Phone:(___) ___ - ___
(Street or Post Office Box)

City: _____ County: _____ State: _____ Zip: _____

Home Address: _____ Phone:(___) ___ - ___
(Street or Post Office Box)

City: _____ County: _____ State: _____ Zip: _____

Name and Address of Physician Assistant School: _____

_____ Date of Graduation: ___ / ___ / ___
(MM/) (DD) (YY)

Are you certified by the National Commission on the Certification of Physician Assistants (NCCPA)? Yes ☐ No ☐

If yes, Certificate No.: _____ Expiration Date: ___ / ___ / ___
(MM) (DD) (YY)

INSTRUCTIONS:

Photographs must be of studio quality with head and shoulder areas only, with features distinct. Photographs must have been taken within the last 12 months.

PHOTO AREA

Paste photograph in this area (do not staple).

Photo may be smaller, but not larger, than this box. Complete and sign the affidavit to the right. Proof photos, negatives, copies of photographs, poor quality digital photos, photographs cut from books or newspaper articles are not accepted.

PHOTO DECLARATION

I hereby declare under penalty of perjury under the laws of the State of West Virginia, that the photo of myself attached hereto, was taken on or about

_____ (Date)

Sex (circle one): M or F

Color of hair _____

Color of eyes _____

Height ___ ft. ___ in. Weight ___ lbs.

Identifying marks: _____

_____
Signature of Applicant

APPLICATION CERTIFICATION

I hereby certify that I have read the instructions (pages i through iii) explaining the licensure requirements for the State of West Virginia, and I understand what I have read and what I am required to produce for licensure in the State of West Virginia. I understand that if I am unable to meet all these requirements, including the production of all required documents and materials, I must be denied licensure in the State of West Virginia. I hereby certify that I am able to meet all these requirements for licensure in the State of West Virginia and that I will be able to produce all required documents and materials and that I will make no request of the Board for a waiver of any of the requirements, including the production of all required documents and materials. I understand that if I make any request for such a waiver, my request must and will be denied.

I understand that if this application is not completed within six (6) months, I will be required to update the application fully. If it is not complete within one year, my application will expire, and I must submit a new application to be considered for licensure in the future.

I have reviewed a current copy of the West Virginia Physician Assistants Practice Act and Legislative Rules, governing the extent to which physician assistants may function in this State. I have read and understand them. I agree that I will abide by the West Virginia Physician Assistants Practice Act and Legislative Rules and any which may from time to time be enacted by the West Virginia Board of Medicine.

I understand that a license to practice as a physician assistant in West Virginia **does not** permit or authorize me to practice in this state until I have filed a proposed practice agreement with the Board and I have received written authorization from the Board to practice under physician supervision within the parameters of the approved practice agreement on file.

Physician Assistant's Signature:_____ **Date:**_____

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 Assistant's Signature:_____ **Date:**_____

PROFESSIONAL PRACTICE, CHARACTER AND FITNESS QUESTIONS

READ EVERYTHING ON THIS PAGE CAREFULLY AND COMPLETELY
FALSE OR FRAUDULENT ANSWERS TO THE FOLLOWING QUESTIONS MAY RESULT IN LICENSURE DENIAL OR REVOCATION

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 your practice as a physician assistant, 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 certificate or license to practice, or had your certificate or license to practice suspended, revoked or subjected to any kind of disciplinary action, including censure, reprimand, or probation, and/or are any disciplinary actions pending against you? ……..….....	☐	☐
5.	voluntarily surrendered or limited your certificate or license to practice? ……..……...	☐	☐
6.	had any hospital privileges 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 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 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 certification or licensure in any state, or been ejected from any physician assistant examination? ……..…….	☐	☐
9.	been denied certification or licensure to practice as a physician assistant? ……	☐	☐
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 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.	failed the NCCPA examination or not maintained certification at any time? …… *If "yes," please provide a written explanation that includes the date(s) of failure and/or lapse in certification and cause.*	☐	☐
14.	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? ……..…… *If "yes," and you have gone through a rehabilitation program at any time, you MUST have that program furnish this Board a report of your treatment and progress.*	☐	☐
15.	had any interruption in your practice which might be 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? …….....	☐	☐
16.	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? …….	☐	☐

I have carefully read and understood all the questions included on each page of this 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 application is based on the truth of the statements contained in this application. Should I furnish any false or misleading information in this application, I hereby agree and understand that any such act shall constitute good cause for licensure denial or the subsequent revocation of any license granted to me.

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

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.

STATE LICENSURE INFORMATION

List all licenses held in other states or jurisdictions regardless of the status of that license (i.e., active, inactive, lapsed, expired, revoked, suspended, surrendered, etc.) and list any state or jurisdiction in which you have ever applied for a physician assistant license, including those where your application is pending or was denied or withdrawn.

Jurisdiction (Allopathic and/or Osteopathic)	Number Issued	Status	Date of Issuance	Date of Expiration

PROFESSIONAL ACTIVITIES AND EMPLOYMENT HISTORY

List in chronological order all of your professional activities and/or places of employment since graduation from physician assistant school. This includes hospitals, teaching institutions, HMO's, private practice, corporations, military assignments, government agencies, locum tenens assignments, and employment outside of practice as a physician assistant.. Also, include all periods of unemployment. A C.V. or resume is not accepted in lieu of completion of this page. If you need additional space, attach an 8½ x 11 sheet of paper. On all attachments, please include your name and the page number of the application. Please provide complete information. Otherwise, requesting additional information from you may lengthen the application process.

From MM/DD/YY	To MM/DD/YY	Employer Name	Employer Address	Position

AFFIDAVIT

I,_____, being first duly sworn, depose and say that I am the person described and identified; that I am of good moral character; that I have not engaged in any of the acts prohibited by the statutes of the State of West Virginia; that I am the person named in the diploma which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby request and authorize all hospitals, medical institutions or organizations, personal references, physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the West Virginia Board of Medicine any information, files, or records required by the Board regarding my clinical ability, education, training, professional ethics, character, physical and mental health, emotional stability, veracity, and any other factors which will or may reflect upon my competence, ethical integrity or physical or mental well-being, for its evaluation of my professional qualifications for licensure in the State of West Virginia. I hereby release all such individuals and entities and their employees, agents and designees from any and all liability for the transmittal of any information or records bearing on my professional qualifications in connection with this request and authorization.

A photocopy of this Affidavit shall have the same force and effect as the original.

_____
Applicant's Signature

Subscribed and sworn to before me this _____ day of _____, _____.
(Month) (Year)

NOTARY SEAL

_____
Signature of Notary Public

_____
Name of State

My commission expires_____/_____/_____.
(MM) (DD) (YYYY)

PHYSICIAN ASSISTANT EDUCATION VERIFICATION

This section to be completed by the applicant.

In applying for a license to practice as a physician assistant, the West Virginia Board of Medicine requires this form to be completed by the school wherein I received my physician assistant degree. This is your authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the West Virginia Board of Medicine, 101 Dee Drive, Suite 103, Charleston, West Virginia 25311. Your prompt response will be appreciated.

Name:_____ DOB:_____/_____/_____

Name as issued on diploma, if different from above:_____

Date of Graduation:_____/_____/_____ SSN:_____-_____-_____

Address:_____
P.O. Box or Street Address City State Zip

Signature:_____Date:_____/_____/_____

CERTIFICATE OF DEAN, SECRETARY, OR REGISTRAR OF COLLEGE

(This form must be completed by a representative of the College)

This is to certify that _____
(Name of Graduate)

has satisfactorily completed_____years of physician assistant education at the

_____, located at
Name of Physician Assistant College

_____.
Mailing Address City State Zip or Postal Code Country

The aforesaid graduate received the degree of_____from

this institution on_____/_____/_____.
Month Day Year

INSTITUTIONAL SEAL

Signature:_____

Title:_____

Date of Signature:_____/_____/_____
Month Day Year

GOOD MORAL CHARACTER STATEMENT

State of_____

County of_____

I, _____, M.D., D.O., or D.P.M .(please circle)
(Name of Affiant) (See Instructions, Page ii)

am currently licensed in the State of _____ and I

swear that I know the applicant, _____ ,to be of good moral
(Name of applicant goes here)

character, and he/she is physically and mentally capable of practicing as a Physician Assistant.

_____
Signature of Affiant

_____
Print Name

_____
Address of Affiant

_____
City State Zip

Sworn to before me this_____day of_____,_____.
(Month) (Year)

My commission expires_____/_____/_____.
Month Day Year

NOTARY SEAL

_____
Signature of Notary Public

Return this form to:

WEST VIRGINIA BOARD OF MEDICINE
ATTENTION: PHYSICIAN ASSISTANT COORDINATOR
101 DEE DRIVE, SUITE 103
CHARLESTON, WEST VIRGINIA 25311

VERIFICATION OF LICENSURE

THIS SECTION TO BE COMPLETED BY APPLICANT:

I,_____, hereby authorize and request the State Board of _____, having control of any documents, records, and other information pertaining to me, to furnish to the **WEST VIRGINIA BOARD OF MEDICINE** information including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent information.

Signature	License Number	Issue Date
Name in Full (Please Print)	Date of Birth	Social Security No.
Other Names Used in Obtaining Licensure	Current Address	

This section is to be completed by an official of the state board and returned to the **WEST VIRGINIA BOARD OF MEDICINE, ATTENTION: PHYSICIAN ASSISTANT COORDINATOR, 101 DEE DRIVE, SUITE 103, CHARLESTON, WV 25311**.

STATE OF:_____

FULL NAME OF LICENSEE:_____

GRADUATE OF:_____

LICENSE NO.:_____ ISSUE DATE:____/____/____ EXPIRATION DATE:____/____/____

CURRENT STATUS:_____

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES____ NO____ UNABLE TO DIVULGE____ (If yes, please attach details)

Have formal disciplinary proceedings ever been initiated against applicant or applicant's license by a disciplinary authority in your state? YES____ NO____ UNABLE TO DIVULGE____ (If yes, please attach details)

Has the applicant ever had his or her certificate or license to practice as a physician assistant limited, conditioned, restricted, suspended, or revoked or subjected to any kind of disciplinary action, including censure, reprimand or probation, or has the applicant every voluntarily surrendered or limited his/her license to practice as a physician assistant, in your state?
YES____ NO____ UNABLE TO DIVULGE____ (If yes, please attach details)

COMMENTS:_____

_____

SIGNED_____

BOARD SEAL

TITLE_____

DATE_____