State of West Virginia
Board of Medicine

101 Dee Drive, Suite 103
Charleston, WV 25311
Telephone 304.558.2921
Fax 304.558.2084
www.wvbom.wv.gov

ALLOPATHIC EDUCATIONAL PERMIT INSTRUCTIONS AND APPLICATION

APPLICANT

1. Complete Section A of the application in full and send the completed original form to your Program Director for finalization.
2. Submit the following directly to the West Virginia Board of Medicine:
    a. A nonrefundable application fee in the amount of $100, payable to the West Virginia Board of Medicine. *The Board accepts credit cards (currently paid by phone with the Board office **after** the application has been received), checks, and money orders;* and
    b. A clear and legible copy of your valid, government-issued identity document bearing your legal name, date of birth and photograph. Accepted documents include:
        - A driver's license or non-driver identification card;
        - A passport or U.S. Global Entry identification card; or
        - A military or national identification card.
3. Before completing Section A of the application, please review the following instructions:
    - **Name:** The name you provide on the application must be your legal name and must match the name on your identification document.
    - **Social Security Number:** You are required to provide your Social Security number on this form. Disclosing your Social Security number is mandatory for the Board to comply with the reporting requirements of the federal National Practitioner Data Bank.
    - **Date of Graduation:** Provide your medical school graduation date as it appears on your diploma. If you are providing an anticipated date of graduation, and the graduation date you have provided changes for any reason, you must notify the Board immediately.
    - **ECFMG:** If you graduated from a medical school outside of the United States, Puerto Rico, or Canada you must provide your ECFMG certification number.

Once you have completed Section A, provide the original application (not a copy) to your Program Director. Your Program Director will complete Section B. The Board only accepts applications which are complete, clear, legible and contain original signatures in Sections A and B.

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PROGRAM DIRECTOR

1. After the permit applicant completes Section A, please complete Section B of the application in full and send the completed original form to the West Virginia Board of Medicine.
2. The Board only accepts applications which are clear, legible and contain original signatures in Sections A and B.
3. The Program Director may designate an individual to complete the application on his or her behalf. To make such designation, the Program Director must submit an original signed letter to the Board which identifies the full name of the designated individual.
4. By certifying the content of the application, you are verifying that the applicant will not commence training until the program has proof of the applicant's medical school graduation.
5. Before completing Section B of the application, please review the following instructions:
   - **Postgraduate Program and Address:** The program name and address will be displayed on the Board's website in association with any permit issued.
   - **Training Level:** Please identify the appropriate training level(s) for the permit period. *(Educational permits expire on June 30th of every year.)* If the applicant is off cycle and will be in multiple training levels during the permit period, please explain on the application.
   - **Training Type:** Identify whether the training is residency training or a fellowship. For fellowship training, the Program Director must verify that prior to fellowship training the applicant has completed an ACGME-approved residency program, or a residency program recognized by the ECFMG.
   - **ACGME:** Please identify whether the training is ACGME approved.
   - **Training Dates:** Provide the start date and end date of the training contract.
   - **Verification:** Please affix the institutional seal to the application form. If a seal is not available, the form may be notarized. All notarized applications must contain original signatures in Sections A, B and in the Notary section.

Once the permit application is processed, the permit applicant will be notified via e-mail. If a permit is granted, it will be emailed to the applicant.

Educational permits expire on June 30th of every year. If a permit holder meets the qualifications for renewal, a renewal application may be submitted.

WEST VIRGINIA BOARD OF MEDICINE
101 DEE DRIVE, SUITE 103, CHARLESTON, WV 25311
(304) 558-2921 https://wvbom.wv.gov

APPLICATION FOR ALLOPATHIC EDUCATIONAL PERMIT

SECTION A: To Be Completed By Applicant

Applicant Name: ____
First Middle Last Suffix

Date of Birth: ____________________ (mm-dd-yyyy) **Social Security Number:** ______________________

Email Address: ______________________________ **Cell/Home Phone:** ____________________

Home Address: ____
(physical address – not a PO Box) City State Zip

Preferred Mailing Address: ____
City State Zip

Medical School of Graduation: ____

City: ______________________ **State:** __________ **Country:** ______________________

Date/Anticipated Date of Graduation: ________________ (mm-dd-yyyy) **ECFMG No.** (if applicable)**:** ________________

I DECLARE THAT the information I have provided in Section A is true and correct. I understand that I have a duty to notify the Board if any of the information in Section A changes.

Applicant's Original Signature: ______________________________ **Date:** ____________________

SECTION B: To Be Completed By Program Director

Postgraduate Program: ______________________________ **Specialty/Subspecialty:** ____________________

Mailing Address: ____**WV**______________
City Zip

Training Level: PGY__________ (e.g., 1, 2, 3) ☐ Residency ☐ Fellowship **ACGME:** ☐ Yes ☐ No

Training Contract Starts: ________________ (mm-dd-yyyy) **Training Contract Ends:** ________________ (mm-dd-yyyy)

I CERTIFY THAT the foregoing is a true and complete statement of the record of the applicant. I certify that the applicant shall not commence training until the program verifies that the applicant has: (a) graduated from an allopathic medical school approved by the LCME; (b) met the requirements for certification by the ECFMG; or (c) has completed an alternate pathway for initial entry or transfer requirements by the ACGME. If this application is for fellowship training, I also certify that prior to commencing fellowship training the applicant has/will complete an ACGME-approved residency program or a residency program recognized by the ECFMG.

Program Director's Printed Name: ______________________________ **Email Address:** ______________________

Program Director's Original Signature: ______________________________ **Date:** ____________________

Affix your institutional seal in the space below. If no institutional seal is available, you must have this form notarized.

Notary (if no institutional seal is available)

State of ____________________, County of ______________________________

I certify that on the date set forth below, the Program Director identified in Section B personally appeared before me and that I identified the affiant by: (a) comparing his/her physical appearance with the affiant's identifying document photograph; and (b) comparing the affiant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the affiant on this

__________day of ____________________ 20________.

Notary's Signature: ______________________________ **My Commission Expires:** ________________