# 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

Dear Applicant:

We thank you for your interest in obtaining a medical license in the State of West Virginia. It is our goal to see that you receive your license in the shortest time possible with as little inconvenience as possible. If you follow the steps outlined below, you will assist in expediting the processing of your application:

1. ***Confirm Eligibility.*** Please determine if you meet the eligibility requirements as listed in these instructions and in the West Virginia Medical Practice Act and Rules prior to making application. As quoted from §30-3-10(i): The Board may not issue a license to a person not previously licensed in West Virginia whose license has been revoked or suspended in another state until reinstatement of his or her license in that state.

2. ***Complete the application as soon as possible.*** The application process will not begin until the Board electronically receives the Uniform Application with fee; and either through the mail or overnight delivery service to the Board office the Photo Affidavit and Addendum 1. Be aware that since licensure approval occurs at the bi-monthly Board meetings, completion of the licensure process generally occurs within three to six months from the date your application is received in this office.

3. ***Be complete.*** We receive information from more than one source. As a result, it is crucial for you to provide complete information. Omissions or discrepancies will delay the process. Send all information and documentation requested. Initial and date each correction you make. Information received in this office from third parties or from your answers to the questions may require clarification or submission of additional materials.

4. ***Follow the directions.*** Do not substitute a different document for the one requested by the Board. Read the instructions in its entirety before you begin completing the application.

5. ***Criminal History Record Check Requirement***. Pursuant to W. Va. Code R. §11-1A-8 et seq. and W. Va. Code R. §11-1B-3.4.-3.18., applicants seeking initial licensure (not renewal or reinstatement) by the West Virginia Board of Medicine are required to request and submit to the Board the results of a fingerprint-based state and national/federal criminal history record check. Please be aware that criminal history record checks may take several weeks to process and cannot be expedited for any reason. Applicants should not request and submit to the Board the results of a criminal history record check until after they have completed a licensure application and paid the appropriate licensing fee. Complete instructions are provided on the Board's website

6. ***Request verifications from third parties immediately upon receipt of the application.*** We accept Physician Information Profiles from the Federation Credentials Verification Service (FCVS). If *not* utilizing this optional service, you should contact those agencies directly to inquire as to the procedure and fee for requesting the information needed by the Board. Send a cover letter with the request form (i.e. Forms 2 or 3) asking the party who will complete the form to assure that all questions are answered, and appropriate signatures and seals are affixed. We suggest you follow up your written requests within two weeks with a phone call to the third party to ensure forms were sent to this office.

7. ***Fees.*** The permanent license fee is $400, payable to the West Virginia Board of Medicine by credit card at the time of completing the West Virginia portion of the Uniform Application. If the fee is not satisfactorily submitted, your application will not be processed. Fees are not refundable under any circumstance.

8. ***Telephone queries about status of applications.*** Unnecessary calls to our office will delay processing time as this takes time away from processing applications. We are required to restrict our response about the status of an application to the applicant or the applicant's attorney, unless you have completed and signed the Authorization for Release of Application Status on Addendum 1 of this application. Within thirty days of receipt of your application in this office, you should receive an e-mail notifying you of the status of your application. If you are concerned about your application being received in this office, please mail it certified – Return Receipt or use overnight mail.

9. ***Tips, Tricks, Hints of the Trade.*** Certain techniques expedite rapid third-party responses. Provide third parties with self-addressed, stamped postcards to be returned to you when documentation is sent to the Board office. Provide third parties with overnight mail envelopes so that the documentation may be forwarded to the Board in a timely manner. For your own records, note the dates of each request sent to third-party agencies.

10. ***Save Time, Save Money, Reduce Anxiety*.** **Do not make commitments on loans, practice start dates, home purchases, airline tickets, etc., until a license is granted.** It may be that not all physicians who apply will receive a license. Don't waste valuable time assuming that an exception will be made or that a requirement will be waived for you.

11. ***Temporary Licensure.*** Fees are not refundable. A temporary license *may* be available to persons actively licensed in another state, the District of Columbia, Canada, or Puerto Rico. The fee for a temporary license is $100, payable to the West Virginia Board of Medicine by cashier's check, money order, personal check, or credit card (via phone call only). Once eligibility is determined and met, only the $100 fee is needed for temporary licensure. There is no additional application.

12. ***License Renewal*.** **Regardless of the date of issuance**, all licensees whose surnames begin with the letters A – L expire on June 30 of every even year, and all licensees whose surnames begin with letters M – Z expire on June 30 of every odd year. The full renewal fee will be required regardless of the date of initial licensure.

If you follow these suggestions in filling out your application, the process should proceed with few complications. We are committed to thoroughly reviewing credentials and to licensing qualified candidates in the shortest possible time.

## Continuing Medical Education Requirements

The West Virginia Board of Medicine *requires* as a condition of **re-licensure** (renewal) that licensees be able to document **fifty (50)** hours of continuing education satisfactory to the West Virginia Board of Medicine *during the preceding two-year period* of which at least **thirty (30)** hours must be related to the physician's area or areas of specialty.

The Legislative Rule explaining what type of continuing education is considered satisfactory to the West Virginia Board of Medicine is available on our website at https://wvbom.wv.gov/LegislativeProcedural%20Rules.asp. **Read Series 1A Licensing and Disciplinary very carefully** as the provisions are *very important* for licensees who hold both active and inactive licenses.

Proof of your continuing medical education is to be available to be sent to the Board at the time of licensure renewal. For those whose *last names begin with A through L,* the two-year period during which continuing education must be obtained began **July 1, 2018** and ends **June 30, 2020**. For those whose *last names begin with M through Z,* the two-year period during which continuing education must be obtained began **July 1, 2017** and ends **June 30, 2019**. No matter when your initial license is issued, your license will expire and must be renewed based on the schedule listed for the first letter of your last name.

## Medical Licensure Requirements

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

1. Graduation and receipt of the degree of doctor of medicine or its equivalent from a school of medicine, which is approved by the Liaison Committee on Medical Education (LCME) or by the Board; <u>and</u>

2. **If an American, Canadian, or Puerto Rican graduate**, successful completion of at least one (1) year of postgraduate clinical training (internship or residency) in the United States, which has been approved by the Accreditation Council for Graduate Medical Education (ACGME); <u>or</u>

   **If a foreign medical graduate**, successful completion of at least two (2) years of postgraduate clinical training (internship, residency or fellowship) in the United States, which has been approved by the ACGME, or successful completion of at least one such year and current certification by a member Board of the American Board of Medical Specialties (ABMS); <u>and</u>

   **<u>One</u>** of the following**:**

   a) **<u>Valid</u>** Educational Commission for Foreign Medical Graduates (ECFMG) certificate; **or**
   b) Evidence of receipt of a passing score on the examination of the ECFMG, **or**
   c) Applicants without an ECFMG certificate provided that the applicant:
      i. is currently fully licensed, excluding any temporary, conditional or restricted license or permit, under the laws of another state, the District of Columbia, Canada or the Commonwealth of Puerto Rico;
      ii. has been engaged on a full-time professional basis in the practice of medicine within the state or jurisdiction where the applicant is fully licensed for a period of at least five years; and
      iii. is not the subject of any pending disciplinary action by a medical licensing board and has not been the subject of professional discipline by a medical licensing board in any jurisdiction, is not required to have a certificate from the educational commission for foreign medical graduates; <u>and</u>

3. **<u>One</u>** of the following:

   a) A Federation Licensing Examination (FLEX) Weighted Average (FWA) of 75% or better obtained at one sitting of the FLEX. Scores averaged together from two or more sittings will not be accepted; **or**
   b) A score of 75% or better on both FLEX Component I **<u>and</u>** FLEX Component II; **or**
   c) A General average score of 75% or better on each of the National Board Examination Parts I, II and III; o**r**
   d) Successful passage of a State Board examination (the Puerto Rico examination is not accepted as it is not solely in English); **or**
   e) Enrollment as a Licentiate of the Medical Council of Canada (LMCC); **or**
   f) Successful passage of the USMLE.

To be eligible for licensure, an applicant **must successfully complete and obtain a passing score equivalent of 75% or better on USMLE Step 1, USMLE Step 2, and USMLE Step 3 within a period of ten (10) consecutive years. Each USMLE Step must be passed individually** in order to successfully complete the USMLE.

The Board (or a majority of them) shall accept a passing score of 75% percent or better on USMLE Step 3, in lieu of a passing score on the FLEX, the NBME or LMCC certificate, or successful passage of a State Board examination. To be eligible for USMLE Step 3, an applicant must have successfully completed and obtained passing scores of 75% or better on **both** USMLE Step 1 and USMLE Step 2.

The USMLE replaces the NBME Part Examination program and the FLEX program, and some medical students and physicians may have successfully completed part of the NBME and/or FLEX program(s). In order to facilitate a smooth transition to USMLE and to avoid undue eligibility burden on applicants for licensure, the Board considers several combinations of these examinations as comparable to the existing examinations. Applicants must reach a passing score of 75% on each examination listed in one of the following combinations:

a) NBME Part I or USMLE Step 1 plus
NBME Part II or USMLE Step 2 plus
NBME Part III or USMLE Step 3; **or**

b) FLEX Component 1 plus USMLE Step 3; **or**

c) NBME Part I or USMLE Step 1 plus
NBME Part II or USMLE Step 2 plus
FLEX Component 2

In order to meet the examination requirement of this subsection for licensure, **the examination combinations set forth in subdivisions a., b., and c., of this subsection, must be successfully completed within a period of ten (10) consecutive years**.

## The Federation Credentials Verification Service (FCVS)

The Federation of State Medical Boards (FSMB) is a national non-profit organization representing the 70 medical and osteopathic boards of the United States and its territories. Two of the services provided by the FSMB are the Federation Credentials Verification Service (FCVS) and the Uniform Application for Physician State Licensure (UA).

FCVS verifies primary source documents related to your identity, education, training, and more, and creates an individualized profile that can be sent to any organization accepting FCVS. By eliminating the re-verification of items that never change, physicians benefit from a shortened credentialing process when applying to more than one state board.

<u>We highly recommend using FCVS for credentials verification but it is not required.</u> If you do not use FCVS, you will need to provide your credentials directly to the Board for verification.

If you would like to use FCVS and haven't used it before, you will need to complete an Initial FCVS Application. If your credentials are already on file with FCVS, you will need to complete a Subsequent Request to update your FCVS profile. All applicants must designate the board to receive the FCVS profile as part of the FCVS application process. Information about FCVS fees can be found at https://www.fsmb.org/fcvs/. These fees are separate from the Board's licensing fee and the UA one-time service fee of $60.00.

**To work on your FCVS application**, visit https://www.fsmb.org/fcvs/ and select "FCVS" in the Sign In menu, then sign in as directed. For assistance with FCVS, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number between 8am and 5pm CT Monday through Friday.

## The Uniform Application for Physician State Licensure (UA)

The UA was developed to streamline and simplify the licensure application process. Once the core UA has been completed, it can be modified and resubmitted to the same board, or used to apply for licensure to additional boards without reentering the same information. Updates can be made as needed.

**<u>The Uniform Application is the board's licensure application and must be completed whether or not you use FCVS for credentials verification.</u>**

You will be asked to complete a chronology of activities of all working and non-working time since medical school graduation. You will also be asked to provide details of any malpractice liability claims. Having this information on hand before you begin will help you to complete the UA more efficiently.

Physicians applying for an initial license and physicians wishing to reactivate a license can access the UA by visiting https://www.fsmb.org/uniform-application/and selecting Uniform Application in the Licensure or Sign In menu, then signing in as directed. If you have submitted a UA previously, select the West Virginia Board of Medicine in the State Board section to open the UA for editing. Submit your UA to the board when you have finished updating your UA.

**Please note the following:**

- Licenses will be issued in your diploma or legal name as indicated on the submitted documented proof of such name (i.e. U.S. Birth Certificate, Certificate of Naturalization, Alien Registration card, Employment Authorization card, and/or legal documentation reflecting name change).

- Provide both your current home address and current business practice/training address, otherwise an error will occur. Do not enter the same address for both home and work.

- 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 and the Healthcare Integrity and Protection Data Bank. If this Board should be required to make a report about one of its applicants or licensees to either of these data banks, it must report that individual's Social Security Number.

- MD licenses cannot be added or edited in the UA as all MD license information comes directly into the system from the state boards. Email ua@fsmb.org with the correct information if changes are needed.

- Enter all other professional licenses (nurse, EMT, physician assistant, etc.) you have held (active or inactive) in the U.S. or Canada. Request verification from these boards by using UA Licensure Verification Form #1, VeriDoc, or follow the instructions on the licensing Boards website.

- If you are applying for a special or temporary license and hold licenses in countries outside the U.S. or Canada, please provide that information on a separate sheet of paper.

- Activities that need to be listed on the Chronology of Activities include hospitals, teaching institutions, HMOs, private practice, corporations, military assignments, government agencies, and Locum Tenens assignments. Exclude postgraduate training (internship, residency, and fellowship) previously entered. Include all periods of unemployment.

- Check the “Staff Privileges” box for all locations where you have had admitting privileges.

- Clinical time indicates time spent with patients. Administrative indicates time spent on paperwork or research.

- In the Malpractice section, for each claim, list the name and the address of the insurance company in the “Insurance carrier at time” field.

- List as much detail as possible in the “specifics” section for each professional liability judgment or settlement, including the name, age, sex of patient/claimant, the nature of the allegations in claims/suits (specify whether a suit was ever filed), names of other practitioners and hospital (if any) involved in claims/suits, name of defense attorney, and reason for settlement.

- At the end of the Core UA, you will be redirected to the West Virginia Board of Medicine licensure portal to allow for electronic transmittal of the Core UA to the Board along with completion of additional information specifically required by the Board and payment of the $400 application fee via credit card.

- In the event the application process is not completed in one sitting, applicants will be sent an e-mail with an application ID number to use to allow access to return to the site at a later time.

**In addition to completing the core UA online, all applicants must:**

- Complete the addenda in this packet as instructed.

  Addendum 1 – Additional Physician Information form. Provide all information requested. Please include the date your Affidavit photo was taken on this page in the space provided. Authorization of someone to assist you with your application is optional.

  Addendum 2 – No longer required effective January 1, 2019.

  Addendum 3 – Affidavit. (*Available upon request*) If you are a foreign medical graduate **without and ECFMG certificate** and relying on option 3.c. (listed on page 2), this form is to be completed by another medical doctor (not a D.O.) who is licensed in the state or jurisdiction where you have been engaged in the practice of medicine on a full-time professional basis for at least five (5) years. The form must be notarized and sent to the Board with this application. Keep a copy of this completed form to take with you to your interview. **Other than the top portion, this is not to be completed by you.**

- Submit a UA Affidavit and Authorization for Release of Information form to the Board. The UA Affidavit is separate from the FCVS Affidavit and must be sent directly to the Board. Securely tape or glue a recent (less than 6 month old) front-view 2"x2" passport-type studio quality color photo of yourself (head and shoulders only) in the square provided. Proof photos, negatives, copies of photographs, poor quality digital photos, and photographs cut from books or newspaper articles are not acceptable. This form must be notarized and mailed to the West Virginia Board of Medicine.

- Have each full, temporary, training, or limited healthcare or profession license or certification you have ever held in the U.S. or Canada verified by the granting board, whether the license or certification is active or inactive. Determine the fees and verification method for each board using the licensure verification resource at https://www.fsmb.org/uniform-application/. Use the UA Licensure Verification Form for boards that need a written request. If the verifying board uses VeriDoc (www.VeriDoc.org) or another method, use that method instead.

**If you are using FCVS for credentials verification,**

- Do not complete the UA Medical Education Verification, Postgraduate Training Verification, or Fifth Pathway Verification forms. Do not send any identity documents, transcripts, certificates, or examination scores to the Board. FCVS handles all of this for you.

**If you are not using FCVS for credentials verification,**

- Send a **copy** of your birth certificate, passport, or baptismal record. No other documents will be accepted in lieu of this requirement.

- Send a **copy** of your marriage license, divorce decree, or court order of change of name if the name shown on your diploma is not the name you are now using. **You will be licensed under the name shown on your medical diploma if evidence is not provided to the Board of a change of name.**

- Contact each appropriate exam entity to have a certified transcript of your scores sent directly to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX),

request your transcript from the NBME. For contact information, see the UA FAQ at https://www.fsmb.org/uniform-application/ua-faq/.

- Complete the UA Medical Education Verification, Postgraduate Training Verification, and Fifth Pathway Verification (if applicable) forms as directed on each form. If transcripts from your medical school are not in English, an original, certified, and official English translation is required.

  - An official English translation is one which is done by:
    - a government official in the U.S.,
    - an official translation service in the U.S. and is qualified to translate,
    - a professor of a language department in a college or university located in the U.S., or
    - an Official of the American Embassy in a foreign country. (This document must be translated by the American Embassy, not just certified as a true copy, and must have the Embassy seal placed on it.)

  - The translator must:
    - Certify that the document is a true translation to the best of his/her knowledge, and that he/she is fluent in the language.
    - Sign the translation; his/her signature must be certified by a Notary Public.
    - Print his/her name and title under the signature.
    - Translate on an official letterhead.

  - For medical schools located in countries experiencing known civil unrest or countries with no diplomatic relationships with the United States, we will accept **notarized letters from two (2) classmates, officials of the school, professors, etc.,** who will sear to your graduation and who were at the school the same time you were. **These letters must give the name of the school, the dates both you and the letter writer started and graduated (month, day, year).** The letters must be received by the West Virginia Board of Medicine directly from the letter writer, not from you. **These letters will not be accepted by the board just because it will take a long time to have your school complete this form.** It will be up to the Board office to which schools cannot or will complete this form.

**<u>You MUST also submit the following to the Board</u>:**

1. **Permanent license fee of $400** by credit card payable when finalizing submission of the UA to the West Virginia Board. **This fee is not refundable under any circumstances. This fee is a separate fee from FCVS fees and the UA fee.**

2. **American Medical Association (AMA) Biographical Profile.** Even if you are not a member of the American Medical Association, you must request the AMA Physician Profile Data Report at https://profiles.ama-assn.org/amaprofiles/. There is a fee for this for non-members. Call customer service at 800-665-2882 for assistance.

3. **National Practitioner Data Bank Self-Query.** Begin the process for a Self-Query at https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp. Follow all instructions given. A pdf of the Self-Query report may be forwarded to the Licensure Analyst processing your application, or you may request a mailed copy so that the Self-Query report is mailed directly to you. You must then mail (do not fax) all of the original report (not photocopies) directly to this office. For assistance, email help@npdb.hrsa.gov or call 800-767-6732.

4. **American, Canadian, or Puerto Rican medical school graduates:** **<u>Copy</u>** of your certificate* of completion of at least one (1) year ACGME approved postgraduate clinical training (internship or residency), in the United States or Canada;

   **<u>OR</u>**

**Foreign medical school graduates:** **Copy** of your certificate* of completion of at least two (2) years of ACGME approved postgraduate clinical training (internship, residency or fellowship), in the United States or Canada, **OR** of at least one year of ACGME approved postgraduate training plus proof of current certification by a member Board of the American Board of Medical Specialties**.**

*If you have not yet received your certificate, proof of completion can be in the form of an official letter (indicating beginning and ending dates of training) from the program director, with the School or Hospital Seal affixed. Submit the original or a copy of the letter with your application. This is in addition to the Postgraduate Training Verification form.

5. If you are a **foreign medical school graduate,** a **valid** copy of your ECFMG certificate (or evidence of receipt of a passing score on the examination); **or** if you were not issued a ECFMG certificate, a completed Addendum 3 attesting to at least five (5) years of full-time practice within the state or jurisdiction where you are fully licensed. To rely on this option, your application must show that you are currently fully licensed (excluding any temporary, conditional or restricted license or permit) under the laws of another state, the District of Columbia, Canada or the Commonwealth of Puerto Rico, **and** that you are not the subject of any pending disciplinary action by a medical licensing board and have not been the subject of professional discipline by a medical licensing board in any jurisdiction.

**For reactivation applicants only: (previously held license expired for more than one year)**

6. **Continuing Medical Education.** In addition to the above requirements, you will need to submit satisfactory evidence of CME completed the previous two years prior to submission of your application. Please refer to the CME requirements on page 2 of the instructions and contact the Board Licensure Analyst at 304-558-2921, ext. 70021, for confirmation of the time periods needed for submission.

   Reactivating applicants do not need to use FCVS or update the existing FCVS profile. The Board has already received the relevant information from your initial licensure application.

For UA assistance, see the UA FAQ at https://www.fsmb.org/uniform-application/ua-faq/. If your issue is not listed, contact UA customer service at 800-793-7939 or ua@fsmb.org with a description of the problem and your username or Federation ID number. Email a screenshot if you see an error.

Please use the checklist at the end of these instructions to ensure that you submit all needed items.

## Board Meetings

Board meetings are held every other month, beginning in January. When your application is processed, you will receive an e-mail notifying you of what documentation is outstanding. When all documentation has been received, you will be mailed or e-mailed a letter of completion. However, if you answer "yes" to any of the Professional Practice Questions in Addendum 1, you may be required to appear before the Licensure Committee and you will not be eligible for a temporary license.

If you are eligible for a temporary license (see page 2) and request a temporary license be issued between the time your application is completed and the Board meeting at which it will be presented, an additional non-refundable fee of **$100.00** is required, in the form of a **cashier's check, money order, or personal check, or by credit card via a phone call. Payment of this fee does not guarantee you a temporary license.** The granting of a temporary license occurs in writing from the Board office.

The West Virginia Board of Medicine will provide reasonable accommodation to a qualified applicant with a disability in accordance with the Americans with Disabilities Act.

## Uniform Application for Physician State Licensure Checklist

Please use the checklist that applies to you. If you are using FCVS for initial credentials verification, you will be responsible for providing or requesting the information for each item not provided by FCVS. If you are applying for license reactivation, you do not need to use FCVS or provide certain materials included in your initial application.

| | Not Using FCVS | Using FCVS **or** License Reactivation |
|---|---|---|
| Submitted the online Uniform Application. | ☐ | ☐ |
| Sent the UA Addendum 1 to the West Virginia Board of Medicine. | ☐ | ☐ |
| Sent the UA Addendum 3 to the West Virginia Board of Medicine, if applicable. Keep a copy for your interview. This addendum is for foreign medical graduates who do **not** have ECFMG certification. (provided upon request) | ☐ | ☐ |
| Sent the Notarized Affidavit and Authorization for Release of Information form to the West Virginia Board of Medicine. | ☐ | ☐ |
| Completed licensure verification with each state board with which you have ever held any healthcare license. Each verifying board will send verification to the West Virginia Board of Medicine. | ☐ | ☐ |
| Requested the Physician Profile Data Report to be sent from the American Medical Association (AMA) to the West Virginia Board of Medicine. | ☐ | ☐ |
| Sent a pdf or mailed the original Self-Query Report received from the National Practitioner Data Bank to the West Virginia Board of Medicine. | ☐ | ☐ |
| Fingerprint-based criminal history record check required for initial and reactivation of licensure – review Board website for submission instruction information. | ☐ | ☐ |
| Paid application fee of $400.00 to the West Virginia Board of Medicine when finalizing submission of the UA. This permanent license fee is non-refundable. | ☐ | ☐ |
| Sent any other required documentation (details for Professional Practice Questions, evidence of CME for license reactivation per renewal requirements on page 2, etc.) to the West Virginia Board of Medicine. | ☐ | ☐ |
| Sent notarized copy of birth certificate or current, valid passport to the West Virginia Board of Medicine. | ☐ | Provided by FCVS or initial application |
| Sent supporting documentation of any legal name change (marriage certificate, divorce decree, or court document) to the West Virginia Board of Medicine. | ☐ | Provided by FCVS or initial application |
| Sent UA Medical School Verification form (Form #2) and a copy of your diploma to each medical school attended. | ☐ | Provided by FCVS or initial application |
| Sent UA Postgraduate Training Verification form (Form #3) to all training programs attended. | ☐ | Provided by FCVS or initial application |
| Sent a copy of your postgraduate training certificate(s) to the West Virginia Board of Medicine. | ☐ | Provided by FCVS or initial application |
| Sent UA Fifth Pathway Verification form (Form #4) to the program director at the medical school/institution, if applicable. This is for physicians who went through a Fifth Pathway program only. | ☐ | Provided by FCVS or initial application |
| Sent all examination transcripts to the West Virginia Board of Medicine. | ☐ | Provided by FCVS or initial application |
| Sent ECFMG certificate to the West Virginia Board of Medicine, if applicable. This is for foreign medical graduates only. | ☐ | Provided by FCVS or initial application |

# 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

## Addendum 1 – Additional Physician Information

**Affidavit and Practice Information**

I certify that I am of good moral character and that I have not engaged in any of the acts prohibited by the statutes of the State of West Virginia. I am applying for licensure by endorsement of examination of (check only one):

☐ NBME ☐ USMLE ☐ FLEX ☐ LMCC ☐ USMLE/FLEX
☐ NBME/USMLE ☐ State Board Exam (State of ____________________)

Practice specialty: _________________________ Proposed WV practice location: __________________

Board Certified in: _________________________ Date Board Certified: _______ /_______ /_________
*mm dd yyyy*

If not currently working as a medical doctor, check here. ☐

**Photo Declaration**

I hereby declare under penalty of perjury under the laws of the State of West Virginia, that the photo of myself attached to the Affidavit and Authorization for Release of Information form was taken on or about ______________________.
*Date*

Sex: ☐ Male ☐ Female Height: ____ ft ____ in Weight: ______ lbs

Hair color: _____________ Eye color: _____________ Identifying marks: _________________

_____________________________________________________________________________________

**Authorization for Release of Application Status**

The person(s) listed below have my permission to check on the status of my application for a West Virginia medical license. I understand that I may revoke this authorization, in writing, at any time during the application process.

_________________________________________ _________________________________________
*Type or print name clearly* *Type or print name clearly*

**Physician's Signature**: _________________________________________ **Date**: ____________________

**Physician's Printed Name**: _________________________________________________________________

**Please return this form to the West Virginia Board of Medicine mailing address above.**

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

## Affidavit and Authorization for Release of Information

**Applicant:** In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

**Send this form to the board you are applying to for licensure.** Include all other required materials. A directory of state medical and osteopathic boards is available at: http://www.fsmb.org/contact-a-state-medical-board/.

Please send this form to: West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, WV 25311

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I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

**Applicant Photograph**

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-type color photo of yourself in this square.

_______________________________________________
*Applicant's signature (must be signed in the presence of a notary)*

_______________________________________________
*Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)*

_______________________________________________
*Date of signature (must correspond to date of notarization)*

**NOTARY**

[Please note: The Notary Public seal should overlap the bottom of the photo to the left. Do not cover the entire face with the seal]

State of ____________________, County of ____________________,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant'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 applicant on this _____ day of ___________, 20____.

Notary Public Signature ___________________________________________ My Notary Commission Expires ______________

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

**Licensure Verification Form** (Form #1)

**Applicant:** Most boards require verification of each professional license ever held. Refer to the licensure verification resource at https://www.fsmb.org/uniform-application/to determine fees and preferred verification method(s) for each state medical and osteopathic verifying board. You may use this form for each board that requires a written request for verification. In Section 1, list the board you are applying to for licensure, using the directory at https://www.fsmb.org/contact-a-state-medical-board/ to ensure you list the correct name and address. Mail this completed form and any required fee to the verifying board.

**Verifying Board:** Unless using electronic verification, complete Section 2 below and mail this form to the board at the address listed in Section 1. Use an additional sheet of paper if needed for explanation(s).

## Section 1: Applicant Information

First name ______________________ Last name ______________________ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name ______________________ Suffix _________SSN* _____________ Birth date (mm/dd/yyyy) _____________

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Authorization for Verifying Board: I am applying for a license to practice medicine. The board that I am applying to for licensure requires that this form or an otherwise accepted method of verification be completed by all boards through which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of _____________ to provide any and all information pertaining to my license number _____________ to the board at the address listed below.

Board name West Virginia Board of Medicine

Mailing address 101 Dee Dr. Suite 103

City/State/Zip Charleston, WV 25311

Applicant signature ________________________________________ Date_______________

## Section 2: Board Verification of Licensure

Name of issuing board or license entity ____________________________________________

Name of licensee (last, first, middle, suffix) ____________________________________________

License type _____________License number _______________ Issue date _____________ Expiration date _____________

1. Is this license current? If not current, please explain: ☐ Yes ☐ No

2. Have formal disciplinary proceedings been initiated against this applicant's license by a disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No ☐ Cannot answer under state law

3. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state? If yes, please explain on a separate sheet of paper and attach it to this form. ☐ Yes ☐ No ☐ Cannot answer under state law

**I CERTIFY THAT** to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature ________________________________

Print name ________________________________

AFFIX INSTITUTIONAL SEAL HERE

Title ______________________ Date _____________

(If no seal is available, this form must be notarized.)

Phone number _______________ Fax number _____________

Email ________________________________

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

## Medical or Osteopathic School Verification Form (Form #2)

**(This is a two-page form)**

**Applicant:** DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form and a copy of your medical school diploma to the current dean of your medical or osteopathic school. Copy this form for multiple schools.

**Dean or Designated Official:** Complete Section 2 of this two-page form and certify the enclosed copy of the diploma by placing your school seal on it. Mail the sealed diploma, an official copy of the physician's transcripts, this completed form, and any other documentation needed to the board at the address listed in Section 1. If transcripts are not in English, an original, certified, and official English translation is required.

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Section 1: Applicant Information

First name ______________________ Last name ______________________ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name ____________________ Suffix ________ SSN* _____________ Birth date (mm/dd/yyyy) ____________

Name if different when diploma awarded: ______________________________________________

Name of school ______________________________________________

*The social security number is to be used for purposes of identification only and may not be used or any other reason.*

Waiver for Release of Information: I am applying for a license to practice medicine. I authorize the medical/osteopathic school listed above to provide any and all information pertaining to my medical/osteopathic education at that institution to the board at the address listed below. I request that the dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached) as described in the instructions above, then mail this completed form, the sealed diploma copy, and a copy of my official transcripts to the board listed below at the given address:

Board name West Virginia Board of Medicine

Mailing address 101 Dee Dr. Suite 103

City/State/Zip Charleston, WV 25311

Applicant signature ______________________________________________ Date _______________

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Section 2: Medical or Osteopathic School Verification

School name ______________________________________________

Complete address w/country ______________________________________________

School name if different when applicant attended ______________________________________________

Hours of undergraduate education required for admission ________ Total weeks of education applicant attended ________

Attendance (mm/yyyy) from __________ to __________ Graduation date __________ Degree awarded __________

### Unusual Circumstances

The following questions apply to unusual circumstances that occurred during any part of the individual's medical or osteopathic education. Check the appropriate responses and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation attached to this form.

1. Do the official records for this individual reflect interruptions or extensions in his/her medical/osteopathic education? **If yes,** indicate the reasons for each interruption or extension, the dates of each interruption or extension, and whether each interruption or extension was approved or unapproved. Yes ☐ No ☐

☐ Personal or family From ____________________ to ☐ Approved ☐ Unapproved

☐ Academic remediation From ____________________ to ☐ Approved ☐ Unapproved

☐ Health From ____________________ to ☐ Approved ☐ Unapproved

☐ Financial From ____________________ to ☐ Approved ☐ Unapproved

☐ Participation in a joint degree program From ____________________ to ☐ Approved ☐ Unapproved

☐ Participation in a non-research special study (e.g., fellowship, intl. experience) From __________ to __________ ☐ Approved ☐ Unapproved

☐ Other __________________________ From __________ to __________ ☐ Approved ☐ Unapproved

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical/osteopathic education? **If yes,** indicate below the reasons for each time of probation and the dates of placement on and removal from probation. Also attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

☐ Academic From ____________________ to ☐ Documentation attached
☐ Unprofessional conduct From ____________________ to ☐ Documentation attached
☐ Behavioral reasons From ____________________ to ☐ Documentation attached
☐ Other __________________________ From __________ to __________ ☐ Documentation attached

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

**I CERTIFY THAT** to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature _____________________________________________
Print name ____________________________________________
Title ____________________________ Date _______________
Phone number _________________ Fax number ___________
Email ________________________________________________

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA UNIFORM APPLICATION FOR LICENSURE

# Postgraduate Training Verification Form (Form #3)

**Institution Name:** ______________________________________________

**Institution Address:** ______________________________________________

______________________________________________

**Affiliated School:** ______________________________________________

**Applicant:** Do not complete this form for verification of accredited training if you are using FCVS. FCVS does not verify non-accredited training. When using FCVS, use this form only if your licensing board requires verification of non-accredited training.

**Program Director or designated Official:** Please complete Section 2, and mail this form and any other items to the designated state medical board at the address listed in Section 1. Thank you.

**Section 1: To be completed by the Applicant.**

**Name:** ______________________________ **Suffix** _____ **Practitioner type: M.D.** ☐ **D.O.** ☐

**Date of birth:** ____________ **(mm/dd/yyyy) SSN*** ______________________________

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

**Name if different when diploma awarded:** ______________________________

**Board Information:** To be completed by the applicant.

**Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined below. I authorize the postgraduate training program listed above to provide any all information pertaining to my training there to the board listed below:**

**Board Name: West Virginia Board of Medicine**

**Mailing address: 101 Dee Drive, Suite 103. Charleston, WV 25311**

Applicant Please Sign Here →

**Applicant Signature** ______________________________ **Date** ____________

**Section 2 : Program Participation :**

**Important:**

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Report Internships, Residencies and Fellowships separately.

**Training Level:** _____ (e.g., 1, 2, 3, etc.)

☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

**Specialty/Subspecialty:** ______________________________

**From:** __/__/______ **To:** __/__/______

**Successfully Completed?:** ☐ Yes ☐ No ☐ In Progress

**Accredited by:** ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

**Training Level:** _____ (e.g., 1, 2, 3, etc.)

☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

**Specialty/Subspecialty:** ______________________________

**From:** __/__/______ **To:** __/__/______

**Successfully Completed?:** ☐ Yes ☐ No ☐ In Progress

**Accredited by:** ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

**Training Level:** _____ (e.g., 1, 2, 3, etc.)

☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

**Specialty/Subspecialty:** ______________________________

**From:** __/__/______ **To:** __/__/______

**Successfully Completed?:** ☐ Yes ☐ No ☐ In Progress

**Accredited by:** ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

**Unusual Circumstances:**

Check the appropriate responses and explain any "Yes" or omitted response(s) on a separate sheet of paper. Attach pages as needed.

1. Did this individual ever take a leave of absence or break from his/her training? ---------------- ☐ Yes ☐ No
2. Was this individual ever placed on probation? ---------------------------------------------------------- ☐ Yes ☐ No
3. Was this individual ever disciplined or placed under investigation? -------------------------------- ☐ Yes ☐ No
4. Were any negative reports for behavioral reasons ever filed by instructors? -------------------- ☐ Yes ☐ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ---------------- ☐ Yes ☐ No

**Certification:** Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

**I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.** This section MUST be signed by the program director (M.D. or D.O. only). **(Signature by personnel other than an M.D. or D.O. must attach an authorization letter. Applicable only for Nevada State Board of Medical Examiners.)**

**Signature:** ______________________________

**Print name:** ______________________________

**Title:** ______________________________

**Email address:** ______________________________

**Phone Number:** ______________________ **Date:** ____________

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

**Fifth Pathway Verification Form** (Form #4)

**Applicant:** DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form to your Fifth Pathway program director.

**Program Director or Designated Official:** Complete Section 2 of this form. Mail this completed form and any other documentation (if applicable) to the board at the address listed in Section 1.

**Section 1: Applicant Information**

First name ____________ Last name ____________ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name ____________ Suffix _____ SSN* ________ Birth date (mm/dd/yyyy) ________

Name if different when diploma was awarded: ____________________

Name of medical school ____________________

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined above. I authorize the designated official to provide any and all information pertaining to my time there to the board listed below:

| | |
|---|---|
| Board name | West Virginia Board of Medicine |
| Mailing address | 101 Dee Drive. Suite 103 |
| City/State/Zip | Charleston, WV 25311 |

Applicant signature ____________________ Date ________

**Section 2: Fifth Pathway Verification**

Institution name ____________________ Affiliated school ____________________

Institution name if different when applicant attended ____________________

Institution address w/country ____________________

| Type of Clinical Rotation | From | To | Weeks Credit |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Completed?
- ☐ Yes. Attendance was from ________ to ________. Completion date was ________.
- ☐ No. Withdrawal* date was ________. **If the applicant withdrew or was dismissed, please explain below.*
- ☐ No. Dismissal* date was ________. **If the applicant withdrew or was dismissed, please explain below*

**I CERTIFY THAT** to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature ____________________

Print name ____________________

AFFIX INSTITUTIONAL SEAL HERE

Title ____________________ Date ________

(If no seal is available, this form must be notarized.)

Phone number ____________ Fax number ________

Email ____________________

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.