State of West Virginia
Board of Medicine

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

PHYSICIAN ASSISTANT REINSTATMENT APPLICATION

Your license to practice as a physician assistant in the State of West Virginia is in an **EXPIRED** status effective March 31, 2019, 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 March 31, 2020. Beginning April 1, 2020, to seek relicensure, you must apply for a new license using the Initial Physician Assistant Licensure Application.

Applications are processed in order of receipt. The staff of the West Virginia Board of Medicine will make every effort to process your application as quickly as possible. To **AVOID** delay in licensure reinstatement, 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**.

Please do not delegate completion of the reinstatement application to any other person. Completion of the reinstatement application is the responsibility of the applicant.

To apply for reinstatement of your physician assistant license with this Board, submit the following:

1. A complete reinstatement application.

2. A nonrefundable reinstatement application fee in the amount of $225.00. Please enclose a check or money order payable to the West Virginia Board of Medicine.

3. Any and all supporting documents and/or responses required in association with your responses to the Professional Practice, Character and Fitness Questions appearing on Page 2 of the application.

4. Documentation supporting your CME attestation on Page 3 of the application.

5. Evidence of registration with the West Virginia Controlled Substance Monitoring Program (CSMP), if applicable.

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 for the Board to comply with the requirements of the federal National Practitioner Data Bank.

WEST VIRGINIA BOARD OF MEDICINE
101 DEE DRIVE, SUITE 103, CHARLESTON, WEST VIRGINIA 25311
304.558.2921 WWW.WVBOM.WV.GOV

APPLICATION FOR REINSTATMENT OF LICENSURE AS A PHYSICIAN ASSISTANT

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

Applicant's Name: ____

Last First Middle/Initial Suffix WV License #

Alternate Name (including maiden name): ____

Last First Middle/Initial Suffix

Date of Birth: ______________________ Social Security Number: ______________________

Email Address: ______________________ Telephone Number: ______________________

Preferred Mailing Address: ______________________ Phone: ______________________

City: __________ County: __________ State: __________ Zip: __________

Home Address: ______________________ Phone: ______________________

City: __________ County: __________ State: __________ Zip: __________

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

If yes, Certificate No.: _________________________ Expiration Date: ___________________________________

Please list all other states and/or jurisdictions where you currently hold or have ever held certification or licensure as a physician assistant:

____

WORKFORCE PLANNING DATA

West Virginia 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 (year): _________________

Percent of Time in Direct Services: _________________ Percent of Time in Administration: _____________________

Revised 4/2019

PROFESSIONAL PRACTICE, CHARACTER AND FITNESS QUESTIONS

Read everything in this section carefully and completely; false or fraudulent answers to the following questions may result in licensure denial or revocation. All "yes" answers must be accompanied by a written explanation, signed and dated by you. You must also enclose all required supportive documentation. **Your application is not complete until all supporting documentation is received. If further information is required, you will be notified.**

At any time since April 1, 2017, 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 (not expired) 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 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? *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? (You may answer "no" if you are a participant in a written voluntary agreement with the West Virginia Medical Professional Health Program, Inc., the West Virginia Board of Medicine designated physician health program.) *If "yes," you MUST have your treatment program furnish this Board a report of your treatment and progress.*		
15.	had any interruption in your practice 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 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?		

Physician Assistant Printed Name:____

Physician Assistant Original Signature: ______________________________________ **Date:**______________

CERTIFICATION OF CONTINUING EDUCATION COMPLIANCE

A. Drug Diversion Training and Best Practice Prescribing of Controlled Substances Training

You must select one.

☐ Between April 1, 2017 and today, I completed a minimum of three (3) CME hours of drug diversion training and best practice prescribing of controlled substances training through a course which has been approved by the West Virginia Board of Medicine. **My CME certificate is included with this application**.

OR

☐ I attest that during the period of April 1, 2017, to present, I did not prescribe, administer or dispense any controlled substances pursuant to a West Virginia license. I request that the Board waive this CME requirement. I understand that I may be audited for independent verification that I have not prescribed, administered or dispensed any controlled substances since April 1, 2017.

B. Other Continuing Education From April 1, 2017 Through the Present

You must select one.

☐ Between April 1, 2017 and today, I have successfully completed a minimum of one hundred (100) hours of continuing medical education satisfactory to the Board. A minimum of fifty (50) hours were designated as Category I CME by either the American Medical Association, American Academy of Physician Assistants or the Academy of Family Physicians. The remaining fifty (50) hours were designated as either Category I CME or Category II CME by the entities listed above. I understand that I can count the mandatory drug diversion training and best practice prescribing of controlled substances training CME in my 100-hour CME total. **My CME certificates are enclosed with this application.**

OR

☐ In addition to either completing the mandatory drug diversion training and best practice prescribing of controlled substances training CME or requesting a waiver of that requirement:

a. Between April 1, 2018 and today, I obtained a master's degree from an accredited program of instruction for physician assistants; or

b. Between April 1, 2017 and today, I have sat for and passed a recertification examination of the NCCPA, **and I have requested that the NCCPA send my Score Report to the West Virginia Board of Medicine**.

PROOF OF CONTROLLED SUBSTANCE MONITORING PROGRAM REGISTRATION

Physician assistants who prescribe or dispense any Schedule III and/or IV controlled substances are required to show proof that they are registered with the West Virginia Controlled Substance Monitoring Program (CSMP) through the West Virginia Board of Pharmacy. **You must select one.**

☐ I am not currently registered with the CSMP. I understand that if I intend to prescribe or dispense any Schedule III and/or IV controlled substances pursuant to my West Virginia license, I must register with the CSMP within thirty days of being granted reinstatement of licensure.

OR

☐ I am currently registered with the CSMP, **and a copy of my West Virginia Board of Pharmacy verification certificate is enclosed**.

CONTINUING EDUCATION AND CSMP REGISTRTION STATUS ATTESTATION

By signing this page of my reinstatement application, I attest that I have provided a true and accurate certification of my continuing education for the period of April 1, 2017 though the present. I also attest that I have accurately reported my CSMP registration status.

Physician Assistant Printed Name: ______________________________________

Physician Assistant Original Signature: ________________________________ **Date:**___________________

CHILD SUPPORT

West Virginia law requires the Board to collect the following information and to advise you 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 amounts 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		

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

APPLICATION CERTIFICATION

I hereby certify that I understand 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 April 1, 2017, and my certification of successful completion of all required continuing medical education.

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 with physician collaboration and within the parameters of the approved practice agreement on file.

I understand that prior to dispensing or administering any controlled substances, including samples, in an office-based setting, I must be registered with the Board as a controlled substance dispensing practitioner for each of my controlled substance dispensing locations.

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 kinds. I declare that my answers and all statements made by me herein are true and correct.

I understand that any license issued based on 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.

Physician Assistant Printed Name: ______________________________________

Physician Assistant Original Signature: ______________________________________ Date:____________