State of West Virginia
Board of Medicine

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2020 REQUEST FOR AUTHORIZATION TO SERVE AS AN UNCOMPENSATED PHYSICIAN ASSISTANT VOLUNTEER FOR A SUMMER CAMP OR PUBLIC OR CHARITABLE FUNCTION – Out of State Licensee

To request authorization for charitable practice, provide the following information. Please print clearly.

First Name Middle Name Last Name Suffix Profession Social Security No.

Your Physical Address City State Zip Code County

Your Preferred Mailing Address City State Zip Code County

Telephone/Cell Number Email Address

1. In the space below, please provide: the name of the event; the sponsoring organization's name, address and contact telephone number; and the nature of the volunteer charitable practice for which you seek authorization (i.e. health fair, etc.).

2. List the specific dates you intend to participate in the charitable practice identified above (your practice may not exceed three weeks): _____

3. Please list each and every state or jurisdiction where you currently hold or have held a professional license at any time in the last three years. If you have additional professional licenses, please attach a separate sheet of paper to your application which identifies all additional professional licenses in a list which conforms to the format below:

State or Jurisdiction	License Number	License Status (Active, Probation, etc.)

4. Have you been disciplined by any licensing board in any jurisdiction for any reason in last three years? _____

5. Are you the subject of any pending disciplinary actions by any licensing board in any jurisdiction for any reason? _____

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By placing my signature hereupon, I attest that the information provided on this Request for Authorization is true and complete. In addition, I attest that: A) the organizers of the summer camp or community event have arranged for a collaborating physician to be available as needed; B) my scope of practice shall be limited to the practice of medical acts which are within my education, training and experience; and C) I will not prescribe any controlled substances or prescription drugs as part of my practice at the above referenced event.

_____ _____

Signature Date