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 PRACTICE NOTIFICATION INSTRUCTIONS

A Practice Notification provides written notice to the Board that a physician assistant ("PA") licensed by the Board will practice in collaboration with one or more physicians in a hospital in the State of West Virginia. To file a Practice Notification, a PA must, in conjunction with the hospital, file a Practice Notification with the Board on the form provided.

The PA shall not commence practice pursuant to a Practice Notification until the Board provides written notification to the PA and the hospital that a complete Practice Notification has been filed with the Board. The Board's written notification **activates** the Practice Notification and provides the PA with authorization to the practice at the identified hospital in conformity with the PA's education, training and experience and in accord with the delineation of privileges granted to the PA by the hospital.

To File A Practice Notification:

1. Submit a complete and legible Practice Notification on the form provided with all required documentation. All Practice Notifications require original signatures. For this reason, Practice Notifications are not accepted by fax or email.
2. A Practice Notification must be completed and signed by both the PA and a representative of the hospital where the physician assistant seeks to practice.
3. Enclose a nonrefundable **$100** fee for each Practice Notification. The Board accepts credit card payments, money orders, and business, personal or cashier's checks. The Board will not accept cash payments.

Instructions:

Page 1:

PA Section: The PA's name must match the PA's legal name on file with this Board. The Board will use email to contact the PA regarding the Practice Notification. Please provide complete and accurate contact information, including a current email address.

Hospital Representative Section: The hospital representative must be authorized to execute the Practice Notification on behalf of the identified hospital(s) and must certify the declarations set forth on Page 2 of the Practice Notification form, as well as **FORM A** (discussed below), if applicable. The hospital representative must identify his/her official job title at the identified hospital and provide his/her email address and phone number at the identified hospital.

Designation of Hospital. The PA and hospital representative must identify the name and physical address of hospital the PA will practice pursuant to the Practice Notification. A PA with an active practice notification on file with the Board may only practice within the hospital identified in the Practice Notification.

A single Practice Notification may designate multiple hospitals **only if** all designated hospitals are operated under the same corporate entity/umbrella. Each hospital location where the PA will practice pursuant to the Practice Notification must be identified in the Practice Notification.

A separate Practice Notification, including an additional $100 Practice Notification Fee, is required for each hospital operated under a separate corporate entity/umbrella.

Page 2:

Additional Required Documents/Information.

1. **Prescriptive Authority/Proof of Required CME**. All Practice Notification must include documentation to establish proof of completion, within the last two years, that the PA completed a minimum of three hours CME hours in a Board-approved course on drug diversion training and best practice prescribing of controlled substances. **This is required for all Practice Notifications** because a Practice Authorization includes prescriptive authority for the PA in accordance with applicable state and federal law and the Board's legislative rules, and subject to any hospital policies or protocols.

2. **Authorization to Complete Death Certificates**. The PA and hospital representative must verify whether the PA has been authorized to complete death certificates and has received appropriate training to do so. If the answer is "NO", the PA is prohibited from completing death certificates until the Board has been notified in writing by the hospital that the PA has been authorized to do so after receiving all appropriate training.

   Practice Via Telemedicine. Please check the appropriate response regarding whether or not your practice at the hospital(s) listed on page 1 will be from a remote location.

   Practice Restrictions/Limitations affecting the PA/FORM A. The PA and hospital representative must indicate whether the PA's license is subject to probation or any practice restriction or limitation.

   If the answer is "NO", no further information is required.

   If the answer is "YES", the PA and the hospital representative must also complete and submit **FORM A** with the Practice Notification. In **FORM A**, the PA and hospital representative must specifically describe the PA's practice limitations/restrictions and certify that the hospital is aware of such and that the PA's hospital practice will comport therewith. Provided, if the PA holds a restricted or limited license which requires practice under direct, on-site or personal collaboration with a collaborating physician, the Board may require the PA to practice pursuant to a practice agreement in all settings until the restriction or limitation is lift.

3. **Certifications**. The PA and the hospital representative are required to certify each of the declarations set forth in the Certifications section by signing and dating the form as indicated. Please review each declaration carefully. The Board only accepts Practice Notifications with original signatures.

WEST VIRGINIA BOARD OF MEDICINE
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Physician Assistant Practice Notification

PHYSICIAN ASSISTANT

Name:_____
First Middle Last Suffix

WVBOM License No.: _____

Email Address: _____ **Phone:** _____

Mailing Address: _____
(Physical address – not a PO Box) City State Zip

HOSPITAL REPRESENTATIVE

Name:_____
First Middle Last Suffix

Job Title: _____

Email Address: _____ **Phone:** _____

Work Address: _____
(Physical address – not a PO Box) City State Zip

HOSPITAL(S)

1. **Hospital**: _____

   Address: _____
   (Physical address – not a PO Box) City State Zip

2. **Hospital**: _____

   Address: _____
   (Physical address – not a PO Box) City State Zip

3. **Hospital**: _____

   Address: _____
   (Physical address – not a PO Box) City State Zip

Additional Required Documents/Information

1. **Prescriptive Authority/Proof of Required CME.** A physician assistant practicing pursuant to an active practice notification has prescriptive authority to prescribe, administer and/or dispense medication in the course of his or her hospital practice in accordance with, and subject to, applicable state and federal law, the Board's legislative rules and any hospital policies or prescriptive authority protocols which further limit or restrict the physician assistant's prescriptive authority. Included with the submission of this practice notification, the physician assistant must provide proof of completion, within the past two years, of a minimum of three hours of a Board-approved CME course on drug diversion training and best practice prescribing of controlled substances.

2. **Answer the following questions by marking the appropriate box:**

Yes	No	
☐	☐	The hospital has authorized this physician assistant to complete death certificates and hereby verifies that the physician assistant has been appropriately trained to perform this medical act.
☐	☐	The physician assistant will be practicing via telemedicine from a remote location to patients located at the hospital(s) listed on page 1.
☐	☐	This physician assistant holds a license that is subject to probation or any other practice restrictions and/or limitations. (*If the answer is YES, you are required to complete and submit **FORM A** in association with this practice notification.*)

3. **Certifications.**

The physician assistant and hospital hereby certify that:

a. The physician assistant shall practice in collaboration with physicians;

b. The physician assistant shall practice in conformity with the physician assistant's education, training and experience and in accord with the delineation of privileges granted to the physician assistant by the hospital;

c. The physician assistant holds a license issued by the West Virginia Board of Medicine to practice as a physician assistant;

d. The physician assistant meets the requirements for prescriptive authority and shall exercise prescriptive authority in conformity with W. Va. Code R. §11-1B-15;

e. The physician assistant will not commence practice pursuant to this practice notification until the physician assistant and the hospital receive written notification from the West Virginia Board of Medicine that this practice notification has been activated;

f. The hospital and physician assistant shall notify the Board within 10 days of the cessation of the physician assistant's practice pursuant to this practice notification.

Physician Assistant	**Hospital Representative**
_____	_____
Printed Name	Printed Name
_____	_____
Original Signature	Original Signature
_____	_____
Date	Date

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Physician Assistant Practice Notification
Form A

Form A. If the physician assistant holds a license that is subject to probation or any other practice restrictions and/or limitations, the physician assistant and hospital representative are required to complete and submit this form in association with a practice notification.

1. **Practice Restrictions/Limitations**. Specifically explain and describe the physician assistant's practice restrictions and/or limitations:

_____

_____

_____

_____

_____

_____

2. **Certifications**. The hospital representative and physician assistant completing this practice notification hereby certify that:
    a. The hospital is aware of the physician assistant's practice restrictions and/or limitations; and
    b. The physician assistant's hospital practice shall comport with all practice restrictions and/or limitations.

Physician Assistant	**Hospital Representative**
_____	_____
Printed Name	Printed Name
_____	_____
Original Signature	Original Signature
_____	_____
Date	Date