State of West Virginia
Board of Medicine

101 Dee Drive, Suite 103
Charleston, WV 25311
Telephone (304) 558-2921
wvbom.wv.gov

PHYSICIAN ASSISTANT PRACTICE NOTIFICATION INSTRUCTIONS

A Practice Notification provides written notice to the Board that a physician assistant ("PA") licensed by or otherwise registered with the Board will practice in collaboration with one or more physicians while practicing to patients in West Virginia. In order to practice in West Virginia, a Practice Notification must be completed and signed by both the PA and a representative of the health care facility where the physician assistant seeks to practice.

A PA shall not commence practice to West Virginia patients until a fully completed Practice Notification is filed with the Board and the Board notifies the PA that the Practice Notification has been activated. An activated Practice Notification provides the PA with authorization to practice at the identified health care facilities in conformity with the PA's education, training and experience and in accord with the delineation of privileges granted to the PA or other credentialing requirements of the health care facility.

To File a Practice Notification:

1. Submit a complete and legible Practice Notification with any required documentation to this Board. The PA and health care facility representative must each personally sign the form.
2. Practice Notifications may be e-filed or mailed. E-filed forms should be sent to the licensure analyst listed below based upon your last name:

Last Names A – G	Last Names H – O	Last Names P – Z
Christina.H.McNealy@wv.gov	Emilie.G.Lloyd@wv.gov	Jessica.N.Luciano@wv.gov

3. The application fee is $100. Please do not include the nonrefundable application fee with your Practice Notification. The West Virginia Board of Medicine accepts online credit card payments for all fees. Upon receipt of your proposed Practice Notification, the Board will send payment instructions viaemail.

Instructions:

Physician Assistant Information. This section is to be completed by the Physician Assistant. A PA's name must match the PA's legal name on file with this Board. If the preferred contact information supplied on this form does not match the preferred contact information currently on file with the West Virginia Board of Medicine, the preferred contact information will be updated to reflect the information submitted on this form. The PA should review the statements included at the end of this section and indicate their agreement

therewith by personally signing and dating on page 1. Information regarding the required 3-hours of Board-approved CME in drug diversion training and best practice prescribing of controlled substances training is available on the Board's website at https://wvbom.wv.gov/Cont_Med_Education.asp.

If the PA is subject to probation or any other practice restrictions and/or limitations, the PA and the health care facility representative must also complete and submit **Form A** with the Practice Notification.

Practice Addresses. Please list the name and physical address of each location the PA will practice pursuant to the Practice Notification. A PA with an active Practice Notification on file with the Board may only practice and prescribe within the health care facility locations identified in the Practice Notification.

A Practice Notification may include multiple practice locations if each of the locations is operated by the same health care facility. A Practice Notification may also include multiple health care facilities if each of the facilities is operated under the same corporate umbrella, and they designate a single representative to execute the Practice Notification on their collective behalf and ensure compliance with the provisions of the Practice Notification certification at every health care facility listed on the Practice Notification.

Individual Practice Notifications are required in all other circumstances.

Certifications. The PA and the health care facility representative are required to certify each of the declarations set forth in the Certifications section by personally signing and dating the form where indicated.

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

Physician Assistant Practice Notification

PHYSICIAN ASSISTANT INFORMATION. This section is to be completed by the physician assistant.

Name:_____
First Middle Last Suffix

I will be practicing pursuant to a:

☐ **WVBOM License** ☐ **WVBOM Interstate Telehealth Registration** ☐ **WVBOM Emergency Registration**

My license or registration number is: _____

Are you currently subject to probation or any other practice restrictions and/or limitations? ☐ **Yes** ☐ **No**
If the answer is YES, you are required to complete and submit FORM A in association with this Practice Notification.

Preferred Contact Information: Preferred Contact Information is the information that the Board will use to contact you, and includes your email address.

Email Address:_____ **Phone:** _____

Street Address: _____

City:_____ **State:**_____ **Zip Code:**_____ **County:** _____

Contact Information. I understand and agree that if the preferred contact information I supply on this form does not match my preferred contact information currently on file with the West Virginia Board of Medicine, my preferred contact information will be updated to reflect the information submitted on this form.
Public Access. I understand that my preferred contact information may be subject to release by the Board pursuant to a public records request.
Continuing Education. I attest that I have read and understand §11-1B-14 Continuing Medical Education Requirements and that if I will prescribe, administer, or dispense any controlled substances whatsoever, I have or will complete a three-hour Board-approved continuing education course on Risk Assessment and Responsible Prescribing of Controlled Substances in compliance with this section.

Physician Assistant Signature_____ **Date** _____

PRACTICE ADDRESS(ES). Please list any and all locations where you may practice in collaboration with physicians pursuant to this Practice Notification. If you have additional practice locations, please utilize Page 3.

Primary Practice Location
Name: _____

Street Address:_____ **Phone**:_____
(Physical address – not a PO Box)

City:_____ **State:**_____ **Zip Code:**_____ **County:**_____

Secondary Practice Location
Name: _____

Street Address:_____ **Phone**:_____
(Physical address – not a PO Box)

City:_____ **State:**_____ **Zip Code:**_____ **County:** _____

CERTIFICATIONS

The physician assistant and health care facility representative 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 or other credentialing requirements of the health care facility;

c. The physician assistant holds a license issued by the West Virginia Board of Medicine to practice as a physician assistant, interstate telehealth registration issued by the Board pursuant to W. Va. Code § 30-1-26, or an emergency registration issued by the Board;

d. The physician assistant meets the requirements for prescriptive authority and shall exercise prescriptive authority in conformity with section fifteen of 11 CSR 1B;

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

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

Notice of activation of this Practice Notification will be provided to the physician assistant and the health care facility representative utilizing the email addresses provided on this form.

Physician Assistant

_____
Printed Name

_____
Original Signature

_____
Date

Health Care Facility Representative

_____
Printed Name

_____
Original Signature

_____
Date

_____
Job Title

_____
Health Care Facility Name

_____
Email Address

_____
Street Address

_____
City State Zip Code

_____
Phone Number

PRACTICE ADDRESSES: ADDITIONAL LOCATION(S)

Please Note: If additional practice locations need to be listed, please complete and submit this form as needed.

1. Location Name: _____

Street Address: _____ Phone: _____
(Physical address – not a PO Box)

_____ County: _____
City State Zip

2. Location Name: _____

Street Address: _____ Phone: _____
(Physical address – not a PO Box)

_____ County: _____
City State Zip

3. Location Name: _____

Street Address: Phone: _____ (Physical address – not a PO Box)

_____ County: _____
City State Zip

4. Location Name: _____

Street Address: _____ Phone: _____
(Physical address – not a PO Box)

_____ County: _____
City State Zip

5. Location Name: _____

Street Address: _____ Phone: _____
(Physical address – not a PO Box)

_____ County: _____
City State Zip

6. Location Name: _____

Street Address: _____ Phone: _____
(Physical address – not a PO Box)

_____ County: _____
City State Zip

7. Location Name: _____

Street Address: _____ Phone: _____
(Physical address – not a PO Box)

_____ County: _____
City State Zip