West Virginia Board of Medicine
Physician Assistant License Application Instructions

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

Physician Assistant Licensure Requirements

Education	Proof of graduation from an accredited program of instruction for physician assistants with a baccalaureate or master's degree.[1]
Examination	Applicants must pass the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA).
Certification	Applicants must hold current certification from the NCCPA or be licensed in good standing in a state that does not require a physician assistant to maintain national certification.
Professional Competency, Statutory Requirements and Public Protection	Applicants must demonstrate professional competency and conduct through responses to 15 Professional Practice, Character, and Fitness Questions.
	Applicants are required to request and submit to the Board the results of a fingerprint-based state and national/federal criminal history record check.
	Applicants must be physically and mentally capable of engaging safely in practice as a physician assistant.
	Applicants cannot have a suspended or revoked physician assistant license, certification or registration in any jurisdiction. The Board may also decline to issue a license to an applicant who is currently subject to any limitation, restriction, suspension, revocation or discipline concerning a physician assistant license, certification or registration in any jurisdiction.
Fee	Applicants must submit a nonrefundable application fee of $250. Please do not send payment with your application. The West Virginia Board of Medicine accepts online credit card payments for all fees. Upon receipt of your application, the Board will send payment instructions via email.

[1] The education requirement may also be satisfied by: graduation from an approved program of instruction in primary health care or surgery prior to July 1, 1994; or through certification by the Board as a Type B physician assistant prior to July 1, 1983.

General Instructions for All Applicants

1. Please review these instructions carefully.
2. Prior to submitting your application and nonrefundable fee, confirm your eligibility for licensure.
3. The West Virginia Board of Medicine requires applicants to personally complete their Application and the WVBOM Photo Affidavit and Authorization for Release of Information. Any errors, omissions or misstatements are solely the responsibility of the applicant.
4. The analyst assigned to your application will send you a written status update upon initial screening, and periodically throughout the application process.
5. The West Virginia Board of Medicine thoroughly reviews your education, practice history, licensure, and any criminal record or disciplinary history. Any unusual circumstances or discrepancies in your application documents will require supplementation and/or other follow-up and may require additional processing time.
6. Applications which fail to complete in six months require the resubmission of several updated application components. Applications which fail to complete within one year expire. Thereafter, a new application is required to pursue licensure.
7. Applications are subject to a continuous supplementation obligation. If any information changes during the application process (i.e. after you start the process and before a licensure decision is rendered or while practicing pursuant to a temporary license) you are obligated to update any and all application components affected by the change in information.
8. Complete applications will be presented to the Board for consideration of licensure at a regularly scheduled Board meeting. The Board meets 6 times a year. Meetings occur in January, March, May, July, September, and November.
9. Some licensure applicants with unusual application circumstances may be required to meet with the Physician Assistant Committee of the Board in advance of licensure consideration.
10. This application requires the submission of your Social Security Number in order for the Board to comply with the reporting requirements of the National Practitioner Data Bank.
11. Some information in your application file is considered public information. Such information includes, but is not limited to your: identity; age (not date of birth); specialty; physician assistant program; graduation date; malpractice history; disciplinary history; city and state of residence; preferred contact information; and current work locations.
12. Please do not make legal commitments (such as purchasing a home, entering into lease agreements, or committing to practice start dates) based upon your expectation of licensure. Not all applicants receive a license, and license applications do not always complete within the anticipated timeframe. Neither applicants nor the Board can control the time frame in which third parties submit required documentation. The Board does not expedite one application in advance of another, nor does it issue licenses if an application is incomplete, or an applicant is ineligible.

Additional Instructions - Physician Assistant Application

1. Personally complete and sign the Physician Assistant License Application. The Board accepts applications which are completed and signed within 30 days of submission to the Board.

2. Answer all questions truthfully and completely, and provide all requested supplemental information. Be sure to:
    a. Provide your personal email address and accurate contact information.
    b. List all of your states of licensure. If you need additional space, use the additional form provided.
    c. Provide a complete Chronology of Activities that begins after your graduation from physician assistant school through the date you submit your application. If you need additional space, use the additional form provided.
    d. Sign and date pages 5 and 6.

3. Mail the following application components directly to the Board:
    a. Completed application with your original signature on pages 5 and 6.
    b. An original WVBOM Photo Affidavit and Authorization for Release of Information.
    c. A legible copy of your physician assistant diploma.
    d. An acceptable identity document (birth certificate, certificate of naturalization or passport).
    e. A National Practitioner Data Bank (NPDB) self-query report. Your report must have been generated with thirty days of the date you provide it to the Board. Instructions for Self-Query requests are located at https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp. You may forward a pdf of the self-query report to the Licensure Analyst assigned to your application, or you may provide the **original** paper copy you receive from the NPDB with your application.
    f. Documentation of:
        1. Your current certification by the NCCPA; or
        2. Verification that you were previously certified by NCCPA and that you hold a current license in good standing from a state that does not require a physician assistant to maintain NCCPA certification.

4. Pay the nonrefundable application fee of $250 online. The West Virginia Board of Medicine accepts online credit card payments for all fees. Upon receipt of your application, the Board will send payment instructions via email. Please do not send payment with your mailed application.

5. Cause the following to be provided directly to the West Virginia Board of Medicine by other entities:
    a. Physician Assistant Education Verification Form – to be submitted by your college or FCVS.
    b. Verification of Licensure – to be submitted by each state or jurisdiction where you are, or have ever been, licensed. Please check each Board's website for instructions on how to request licensure verification.[2]
    c. A copy of your PANCE score report. Visit the National Commission on Certification of Physician Assistants' (NCCPA) website at www.nccpa.net to electronically release your PANCE score to the Board. Letters verifying certification or the PANRE score will not be accepted in lieu of a score report.
    d. The results of a fingerprint-based state and national/federal criminal history record check. The Board is not permitted to utilize background checks performed for other entities. Fingerprinting services are provided by IdentoGo for a fee of $45.75. The 6-digit service code for the West Virginia Board of Medicine is 228Q9Z. Complete instructions are available on the Board's website here: https://wvbom.wv.gov/Criminalhistory.asp.

[2] The Board also accepts verification of licensure from VeriDoc, for states that use this service.

WVBOM Photo Affidavit and Authorization for Release of Information

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

First: **Middle:** **Last:** **Suffix:**

Profession Type: ☐ **MD** ☐ **DPM** ☐ **PA**

Identifying Characteristics

Sex: ☐ **Male** ☐ **Female**

Height (ft.in): _____

Weight (lbs.): _____

Hair Color: _____

Eye Color: _____

Identifying Marks: _____

_____

Date attached photo was taken: _____
(mm/dd/yyyy)

Applicant Photograph

Securely tape or glue a front-view 2" x 2" passport-type color photo of yourself in this square. Photo must be clear, accurately depict the applicant, and have been taken within 12 months of the date the Board receives this form.

PHOTO MUST BE ATTACHED PRIOR TO NOTARIZATION

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 license. I understand that I may revoke this authorization, in writing, at any time during the application process. (If you do not want to authorize anyone else to receive status updates, please leave this section blank.)

_____ _____
Type or print name clearly *Type or print name clearly*

Applicant's Signature: _____ **Date:** _____
(mm/dd/yyyy)

Notarized Affidavit and Authorization for Release of Information

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 Licensure Application I submitted to this Board 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.

Continued on page 2

Continued from page 1

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's printed legal name

_____

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

_____

Date (must be dated in the presence of a notary and correspond to date of notarization)

Notary

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.

State of _____ County of _____ The statements

on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20_____.
Day *Month* *Year*

Notary Public Signature: _____ [Notary Seal]

My Notary Commission Expires: _____

Practice Information

Do you have proposed practice plans for West Virginia? YES ☐ NO ☐
If yes, please describe your practice plans and proposed practice location:

Plans: _____ Location _____

Do your practice plans involve practice via telehealth? YES ☐ NO ☐

Are you currently working as a provider? YES ☐ NO ☐
If no, how long have you been absent from clinical practice? _____

FOR MDs AND DPMs ONLY

List your area of practice specialty: _____ Are you board certified? YES ☐ NO ☐

If yes, please list your certifying board: _____

Mail original form to:
West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, WV 25311

West Virginia Board of Medicine
Physician Assistant License Application

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

Personal Information – In accord with federal law, please be advised that disclosure of your Social Security Number is MANDATORY in order for the Board to comply with the requirements of the federal National Practitioner Data Bank. Please be advised that contact information may be subject to release by the Board in response to a public records request.

Legal Name:_____
First Middle Last Suffix

Alternate Name(s): _____
First Middle Last (Maiden)

Date of Birth: _____ (mm/dd/yyyy) Social Security Number: _____

Please select the type of identity document you have enclosed with your application:

☐ Certified Birth Certificate ☐ Passport ☐ Certificate of Naturalization

Home Address - Your home address is your principal place of residence and is a physical address. Please do not use a post office box as your home address.

Street Address: _____ Telephone: _____

City:_____ State:_____ Zip Code:_____ County:_____ Fax: _____

Preferred Mailing Address / Contact Information - Your preferred contact information, including your email address, is the information that the Board will use to contact you.

Business Name (if applicable):_____

Street Address:_____Telephone:_____

City:_____ State:_____ Zip Code:_____ County:_____ Fax: _____

Email Address: _____ Mobile Telephone: _____

Professional Education - Please enclose a legible copy of your diploma with your application. If you have not already done so, please submit the Physician Assistant Education Verification Form to your school for completion. Your school will return the form directly to the Board.

Name of PA School: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Degree Earned: _____ Date of Graduation: _____ (mm/dd/yyyy)

Examination and Certification

Date you passed the NCCPA's Physician Assistant National Certifying Examination (PANCE): _____

Please select the appropriate option regarding your current NCCPA certification status:

☐ I have never held NCCPA certification.

☐ I am currently certified by the NCCPA:
NCCPA Number:_____ Expiration Date: _____

☐ I am not currently NCCPA certified, but I am currently licensed in the following state that does not require maintaining NCCPA certification for licensure:

State:_____ License No.:_____ Expiration Date:_____

State Licensure History - If you have not already done so, please request verification of each of your licenses, regardless of current status. The verifying authority will submit your license verifications directly to the Board.

Have you ever been denied a license, certification or registration to practice in another jurisdiction?
☐ Yes ☐ No
Have you ever withdrawn a license, certification or registration application in another jurisdiction?
☐ Yes ☐ No
Do you or have you ever held a license, certification or registration to practice in another jurisdiction?
☐ Yes ☐ No
Have you ever had a physician assistant license, certification or registration suspended or revoked in any jurisdiction?
☐ Yes ☐ No

Please list all licenses, certifications, or registrations you have received in all other states or jurisdictions, regardless of the current status of that license (i.e., active, inactive, lapsed, expired, revoked, suspended, surrendered, etc.) and list any state or jurisdiction in which you have ever applied for a physician assistant license, including those where your application is pending or was denied or withdrawn. If you need additional space, please continue your information on the Additional Licenses Chart included in your application packet. While not required, alphabetization by state is appreciated.

State & Board Type (Allopathic or Osteopathic)	License Number	Status	Date Issued	Date of Expiration

Chronology of Activity - List in chronological order all of your professional activities and/or places of employment since graduation from physician assistant school. This includes hospitals, teaching institutions, HMO's, private practice, corporations, military assignments, government agencies, locum tenens assignments, and employment outside of practice as a physician assistant. Also, include all periods of unemployment. If you need additional space, please continue your information on the Additional Chronology Chart included in your application packet. Please provide complete information. If you are a new graduate and have no professional activity after graduation, please check the new graduate box.

☐ I graduated from my PA program within the last 60 days and I have no chronology of activity to report at this time.

Begin Date (mm/dd/yy)	End Date (mm/dd/yy)	Employment / Practice Location Name and Address	Description of Activity (PA work, non-PA work, vacation, seeking employment, etc)

Medical Corporation or Professional Limited Liability Company - Please list each medical corporation or professional limited liability company for which you are currently a shareholder, owner, member or partner.

_____

_____

☐ I am not a shareholder, owner, member or partner of a medical corporation or a professional limited liability company.

Professional Practice, Character, and Fitness Questions - 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 PA practice, or for unethical conduct?	☐	☐
2	been charged with **or** convicted of **or** pled nolo contendere to any felony or misdemeanor? If your answer is yes, 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? If your answer is yes, 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 license to practice, or had your license to practice suspended, revoked or subjected to any kind of disciplinary action, including censure, reprimand or probation by a medical board, **and/or** are any disciplinary actions pending against you?	☐	☐
5	voluntarily surrendered or limited your license to practice to a licensing board or equivalent authority?	☐	☐
6	had any hospital privileges, limited, restricted, suspended, revoked, or subjected to any kind of disciplinary action, including censure, reprimand or probation? If your answer is 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 medical professional liability settlement or judgment you report, please provide: (1) the name of the patient(s) alleging medical professional liability; (2) the date of loss; (3) the date of the settlement or judgement; (4) the amount of the settlement or judgement against you; (5) the name of the insurance company providing coverage to you with respect to this claim; and (6) a brief description of the allegations and a summary of the care provided. Your application is incomplete until all of the requested information is submitted for each settlement and/or judgement.	☐	☐
13	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 Professionals Health Program, Inc., the West Virginia Board of Medicine designated physician health program.) If you answer yes and have gone through a rehabilitation program, you MUST have that program furnish this Board a report of your treatment and progress.	☐	☐
14	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?	☐	☐
15	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?	☐	☐

Professional Practice, Character, and Fitness Attestation - All of my responses to the questions on this page are truthful and complete. If I have "yes" responses, I have enclosed written explanations, with my original dated signature for each question, and I have enclosed or caused to be submitted all requested supporting documentation.

Original Signature: _____ **Date:_____**

Child Support – The following certification is required by state law, and "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. If you answer "yes" to any of the below questions, and if further information is needed, you will be notified.

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 amount equals or exceeds the amount of child support payable for six months.		
3.	I am the subject of a child support related subpoena or warrant.		

Application Certification

I understand that I am required to personally complete this application, and I am solely responsible for the accuracy and completeness of the information provided.

I have carefully read and understood the application instructions and all questions included on each page of this application, and I have answered all the questions completely, without reservations of any kind. I declare that my answers and all statements made by me herein are true and correct.

I understand the requirements and eligibility criteria for receipt of a physician assistant license, and agree that if I am unable to meet all these requirements, including the production of all required documents and materials, I will be denied licensure by the West Virginia Board of Medicine. I hereby certify that I am able to meet all these requirements for licensure in the State of West Virginia and that I will be able to produce all required documents and materials and that I will make no request of the Board for a waiver of any of the requirements, including the production of all required documents and materials. I understand that if I make any request for such a waiver, my request must and will be denied.

I understand that my application will not be considered until I produce all required application components. I understand that if this application is not completed within six (6) months, I will be required to update the application fully. If it is not complete within one (1) year, my application will expire, and I must submit a new application to be considered for licensure in the future.

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 Notification with the Board and I have received written authorization from the Board to practice in collaboration with physicians.

I understand that any license issued based on this application is contingent upon the truth of the statements contained herein. Should I furnish false or misleading information in this application, I hereby agree and understand that any such act shall constitute good cause for license denial and/or the subsequent revocation of my license.

I agree that I will supplement this application if any of my answers should change between now and when my application is considered for licensure.

Original Signature: _____ **Date:_____**

West Virginia Board of Medicine License Application
Additional Licenses Chart

Applicant Name: _____

State & Board Type (Allopathic or Osteopathic)	License Number	Status	Date Issued	Date of Expiration

West Virginia Board of Medicine License Application
Additional Chronology Chart

Applicant Name: _____

Begin Date (mm/dd/yy)	End Date (mm/dd/yy)	Employment / Practice Location Name and Address	Description of Activity (PA work, non-PA work, vacation, seeking employment, etc)

West Virginia Board of Medicine
Physician Assistant Education Verification Form

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

To Be Completed by Applicant

I hereby authorize my physician assistant college, _____, to complete this form and release any information in your files of record, favorable or unfavorable, **DIRECTLY** to the West Virginia Board of Medicine, 101 Dee Drive, Suite 103, Charleston, West Virginia 25311. My application for West Virginia licensure will not be complete until my school submits this original form.

Legal Name:

_____

First **Middle** **Last** **Suffix**

Diploma Name (if different):

_____

First **Middle** **Last (Maiden)**

DOB: _____/_____/_____ Graduation Date: _____/_____/_____ SSN: _____-____-_____

Applicant's Signature: _____ Signature Date: _____/_____/_____

To Be Completed by Representative of College

CERTIFICATION OF DEAN, SECRETARY, OR REGISTRAR OF COLLEGE

(This form must be completed by a representative of the College)

I hereby certify that _____

(Name of Graduate)

has satisfactorily completed _____ years of physician assistant education at:

Name of PA School: _____

Address: _____ City: _____ State: _____ Zip: _____

Degree Earned: _____ Date Degree Conferred: _____/_____/_____

INSTITUTIONAL SEAL

Signature: _____

Title: _____

Date: _____