State of West Virginia
Board of Medicine

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

INTERSTATE TELEHEALTH REGISTRATION APPLICATION AND INSTRUCTIONS

The West Virginia Board of Medicine is authorized to issue Interstate Telehealth Registrations to eligible medical doctors (MDs), podiatric physicians (DPMs) and physicians assistants (PAs) who seek to provide telehealth services to patients located in West Virginia from another US state. An Interstate Telehealth Registration is not a license to practice medicine and surgery in West Virginia, and only authorizes the registrant to provide telehealth services to West Virginia patients. Practitioners who seek to treat patients in person in West Virginia, or who seek to provide telehealth services from an international location must hold an active status West Virginia medical, podiatric or physician assistant license.

A practitioner (MD, DPM or PA) is eligible to apply for an interstate telehealth registration issued by the Board if all of the following requirements are continuously met:

1. The practitioner holds a valid, active medical, podiatric or physician assistant license issued by another state licensing authority or board;

2. The practitioner is licensed in good standing in all states in which the practitioner is licensed;

3. The practitioner is not the subject of an administrative complaint which is currently pending before another state licensing authority or board; and

4. The practitioner is not currently under investigation by another state licensing authority or board.

INSTRUCTIONS

To apply for an Interstate Telehealth Registration, please complete the following steps.

1. **Application.** Complete the Interstate Telehealth Registration Application in full. Please utilize Page 5 only if you have obtained licensure in more than six jurisdictions. Please do not delegate completion of your application to any other person; it is solely the

responsibility of the applicant. Please review the entire application to verify that each entry is correct and complete. Illegible applications will be returned.

2. **Fee.** The West Virginia Board of Medicine accepts online credit card payments for all fees. Please do not send payment with your application. Upon receipt of your application, the Board will send payment instructions via email.

INITIAL APPLICATION FEE

MD	**$175**
DPM	**$175**
PA	**$100**

3. **Proof of Identity**. Submit a copy of your birth certificate, certificate of naturalization, or passport with your application.

4. **Evidence of Professional Education.** Submit a copy of your original diploma and/or certificate showing completion of your medical school, podiatric school or physician assistant program of education with your application. You must also submit a certified translation if your original education document is not in the English language.

5. **Verify Licensure.** You must verify each of your current and former professional licenses. License verifications must be sent to this Board directly from each issuing board. Please follow the requirements of the issuing board(s) to request verification of your license. Some boards may contract with VeriDoc, www.veridoc.org, for this service. A processing fee may be required by the issuing board.

6. **Mail Application.** Because your original signature is required, your application must be mailed. The Board does not accept applications via facsimile or email. Please keep a copy of your complete application for your records. Mail your completed application form, identity document, and professional diploma/certificate to:

WEST VIRGINIA BOARD OF MEDICINE
101 Dee Drive, Suite 103
Charleston, WV 25311

Your application is not complete until all component parts, including all license verifications, and payment of the application fee have been received. You may not provide telehealth services to patients located in West Virginia while your application is pending. Once your application is complete, it will be reviewed for eligibility. Thereafter, the Board will notify you, via email, of the disposition of your application.

Interstate Telehealth Registration Application

(For the registration period ending March 31, 2026)

Profession Type: ☐ **Medical Doctor** ☐ **Podiatric Physician** ☐ **Physician Assistant**

Name: _____
First **Middle** **Last** **Suffix**

Other name(s): _____
First **Middle** **Last (maiden)**

Identifying Characteristics

Sex: ☐ **Male** ☐ **Female**

Height (ft.in): _____

Weight (lbs.): _____

Hair Color: _____

Eye Color: _____

Identifying Marks: _____

_____

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

Paste or tape a recent color photo taken within the past 12 months, front-view passport-type photo in this square

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.

Date of Birth: _____ **City:** _____**State/Province:**_____
(mm/dd/yyyy)

County: _____ **Country:** _____

Social Security Number: _____

Professional Education

Degree Earned: ☐ **Doctor of Medicine** ☐ **Doctor of Podiatric Medicine** ☐ **Physician Assistant Program**

Name of School: _____

City: _____ **State/Province:** _____

Country: _____ **Date of Graduation:** _____
(mm/dd/yyyy)

Name: _____

Please be advised that your preferred contact mailing address may be subject to release by the Board.

Preferred Contact Information - Preferred contact information is the information that the Board will use to contact you. The Board may also contact you at any email address you provide.

Business Name (if applicable):_____

Street Address:_____ **Telephone:**_____

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

Email Address: _____ **Mobile Telephone:** _____

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:** _____

Primary Work Address - Your primary work address is publicly available on the West Virginia Board of Medicine website.

Business Name (if applicable): _____

Street Address: _____**Telephone:** _____

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

Licensure History and Status: Please list each and every state and commonwealth where you have ever been licensed and provide the requested information. **Please use Page 5 if additional space is needed to complete this list.**

State	License Number	Date Issued	Status

Name: _____

Please provide complete and accurate answers to the following questions concerning your out of state licensure. For the purpose of these questions "professional license" means a license to practice medicine, podiatric medicine or as a physician assistant in any state or commonwealth of the United States.

ALL YES ANSWERS MUST BE ACCOMPANIED BY A WRITTEN EXPLANATION, SIGNED AND DATED BY YOU, EXPLAINING IN DETAILYOUR YES ANSWER(S). YOU MUST ALSO ENCLOSE OR CAUSE TO BE SUBMITTED ALL REQUESTED SUPPORTIVE DOCUMENTATION.

	Yes	No
1. Do you have any limitations, restrictions or conditions placed upon any of your professional licenses by any medical board?	☐	☐
2. Have you ever had a professional license revoked, suspended, or placed on probation?	☐	☐
3. Have you ever surrendered a professional license?	☐	☐
4. Have you had disciplinary action taken against your professional license(s) in any jurisdiction?	☐	☐
5. Are you currently under investigation or subject to an administrative complaint in any jurisdiction related to your professional conduct or professional licensure?	☐	☐

Acknowledgement / Certification

By affixing my personal signature to this application, I hereby certify:

Personal Completion of Application and Accuracy. I have personally completed this Interstate Telehealth Registration Application, and I am solely responsible for the accuracy and completeness of the information provided. I have carefully read and understood all of the questions and have answered them completely, without reservations of any kind. I declare that my answers and all statements made by me herein are true, correct and complete. I understand that any authorization to practice issued to me is based on the truthfulness of the information I have provided and my statements herein. I hereby agree and understand that providing false or incomplete information on this application constitutes good cause for disciplinary action and/or the subsequent revocation of any practice authorization issued to me by this Board.

Duty to Supplement. I understand and agree that if anything should occur which would change how I responded to any of the application questions, or which would render my original responses untrue, inaccurate or incomplete, I have a duty to supplement my responses until such time as I am notified by the Board that it has acted upon this application.

Standard of Care. I understand that the standard of care requires "that with respect to the established patient, the patient shall visit an in-person health care practitioner within 12 months of using the initial telemedicine service or the telemedicine service shall no longer be available to the patient until an in-person visit is obtained. This requirement may be suspended, in the discretion of the health care practitioner, on a case-by-case basis, and it does not [apply] to the following services: acute inpatient care, post-operative follow-up checks, behavioral medicine, addiction medicine, or palliative care." W. Va. Code § 30-1-26(b)(4).

Name: _____

Prescribing Limitations. I understand that if I prescribe medication to West Virginia patients, I must comport my prescribing to the standard of care and all restrictions and/or limitations set forth in West Virginia law and federal law. I acknowledge that interstate telehealth registrants are generally prohibited from prescribing any controlled substance listed in Schedule II of the Uniform Controlled Substance Act, with limited exceptions which are set forth in state law. Prior to prescribing any controlled substance to West Virginia patients I agree to review and familiarize myself with the prescribing prohibitions, limitations and authorizations set forth in the West Virginia Code and the Board's legislative rules.

Duty to Report. I understand and agree that if registered to provide telehealth services in West Virginia, I am obligated to immediately notify the Board of Medicine of any action taken against any of my professional licenses in other jurisdictions.

Discipline and Jurisdiction. By registering to provide telehealth services to patients in West Virginia, I understand and agree that I am subject to the laws, rules and regulations of West Virginia governing my profession, including the state judicial system and all professional conduct rules and standards incorporated into the practice act governing my profession and all of the Board's legislative and procedural rules. I acknowledge and agree that I am subject to the jurisdiction of the West Virginia Board of Medicine, including the Board's complaint, investigation and hearing process.

Interstate Telehealth Registration is not a License. I understand that an Interstate Telehealth Registration is not a license to practice medicine and surgery in West Virginia, and the authorization it grants is limited to the provision of telehealth services to patients located within the State of West Virginia while I am physically located in another state or commonwealth of the United States. I understand and agree that in the event I seek to practice medicine and surgery while physically present within West Virginia, I must apply for and be issued a West Virginia medical license.

Duty to Maintain Current Contact Information. I understand that I have an obligation to maintain complete and up-to-date contact information with the West Virginia Board of Medicine and agree to provide updated contact information within 10 business days of any change to the information submitted with this application.

Renewal. I understand that the Board of Medicine issues Interstate Telehealth Registrations for a specific term, and that if I intend to continue to provide interstate telehealth services to patients located in West Virginia after the initial term of registration, I must apply for registration renewal.

Collaborative Practice. Physician assistants who register to provide interstate telehealth services to West Virginia patients must submit a Practice Notification and receive notice from the Board prior to commencing practice.

Original Signature: _____ Date: _____

Name: _____

Additional States and/or Commonwealth in which you are or have ever been licensed (continued from Page 2):

State	License Number	Date Issued	Status