

WEST VIRGINIA BOARD OF MEDICINE
101 DEE DRIVE, SUITE 103, CHARLESTON, WEST VIRGINIA 25311
(304) 558-2921
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WWW.WVBOM.WV.GOV

NOTIFICATION OF TERMINATION OF A PRACTICE NOTIFICATION

REPORTING REQUIREMENT: A physician assistant shall immediately cease practicing upon the termination of a Practice Notification. The physician assistant must notify the Board, in writing, within ten (10) days of the termination of any Practice Notification (W. Va. Code R. §11-1B-11.12).

INSTRUCTIONS: This form is to be completed by the physician assistant. Acknowledgement of receipt will be provided to the physician assistant and the designated health care facility representative via e-mail.

Effective Date of Termination	
Date (mm/dd/yyyy)	
Physician Assistant Information	
License #:	
Last Name:	First Name:
E-mail Address:	Telephone #:
Health Care Facility Information for a Practice Notification	
Health Care Facility Name:	
HCF Representative Email Address:	
Reason(s) for Termination: Reasons may include voluntary resignation, resignation after a notice of intent to terminate, change of employment, etc.	
Physician Assistant Signature	
Physician Assistant (Print or Type)	
Physician Assistant (Personal Signature)	Date