

West Virginia Board of Medicine
Domestic Medical Corporation Reinstatement Application

The Board does not accept applications which contain electronically generated or stamped signatures.

CORPORATION INFORMATION

Name of the Corporation: _____

Previous Registration Number: _____ FEIN: _____

CONTACT INFORMATION

Main Office Location – This address is displayed on the Board’s website.

Street Address: _____

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

Telephone Number: _____ Fax Number (if applicable): _____

Preferred Contact Information – All correspondence from the Board will be sent to this address and/or this email address.

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number (if applicable): _____

Email Address: _____

SHAREHOLDERS

Each shareholder must be a licensed physician (allopathic, osteopathic or podiatric) or a physician assistant, and must hold an active status West Virginia license that is in good standing. If there are more than two shareholders, please provide the information for the additional shareholders on a separate sheet of paper using the format below.

Name: _____ Name: _____

Profession (MD, DPM, DO, PA): _____ Profession (MD, DPM, DO, PA): _____

WV License Number: _____ WV License Number: _____

Signature: _____ Signature: _____

CERTIFICATION

As a shareholder of the above-named corporation, I certify that this application is true and complete.

Signature: _____ Date: _____

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Mail the completed application to:

West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, West Virginia 25311

Please do not include the \$500 application fee 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 to the email address provided on the application.