West Virginia Board of Medicine
Foreign 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: _____

ADDRESS/CONTACT INFORMATION

Address in State of Incorporation

Street Address: _____

City: _____ State: _____ Zip Code: _____

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: _____

Proposed West Virginia Practice Location

Street Address: _____

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

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

☐ I will not have a physical work location in West Virginia.

SHAREHOLDERS

Each shareholder must be a licensed physician (allopathic, osteopathic or podiatric) or a physician assistant, and at least one shareholder must hold an active status West Virginia license that is in good standing.

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Name of the Corporation: _____

West Virginia Designated Corporate Shareholder

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

Street Address: _____

City: _____ State: _____ Zip Code: _____

West Virginia License Number: _____

Designated Corporate Shareholder Signature: _____

Additional Shareholders - If there are more than three shareholders, please provide the information for each additional member on a separate sheet of paper using the format below.

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

Street Address: _____

City: _____ State: _____ Zip Code: _____

State(s) of Licensure and License Number(s)

State of Licensure	License Number

Shareholder Signature: _____

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

Street Address: _____

City: _____ State: _____ Zip Code: _____

State(s) of Licensure and License Number(s)

State	License Number

Shareholder Signature: _____

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Name of the Corporation: _____

CERTIFICATION

On behalf of the above-named medical corporation, I hereby certify that the information provided in this application is true and correct.

I understand that the corporation must include a licensed West Virginia shareholder for the Certificate of Authorization to remain valid.

Shareholder Signature: _____ Date: _____

Please submit the following documents in association with your application:

- Documentation which demonstrates that the medical corporation is authorized and is currently in good Standing in its state of incorporation.

Mail the completed application, with all associated documents 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.