State of West Virginia
Board of Medicine
101 Dee Drive, Suite 103
Charleston, WV 25311
Telephone: (304) 558-2921
www.wvbom.wv.gov

LIMITED TIME RECIPROCAL EDUCATIONAL PERMIT APPLICATION AND INSTRUCTIONS

This application is for out of state medical residents participating in a training rotation in West Virginia for a period of up to 60 days.

The Board only accepts applications which are: complete; legible; contain original signatures in Sections A and B; and are accompanied by a copy of the applicant's proof of identity document .

SECTION A: To Be Completed by Applicant

- **Name:** The name you provide on the application must be your complete legal name (first, middle and last) and must match the name on your identification document.
- **Social Security Number:** You are required to provide your Social Security number on this form. Disclosing your Social Security number is mandatory for the Board to comply with the reporting requirements of the federal National Practitioner Data Bank.
- **Contact Information:** Provide your current contact information. A valid email is necessary to receive a copy of your wallet card and Board communications. You may write "same" if your preferred mailing address is your home address. Please contact the Board office if your contact information changes.
- **Out-of-State Residency Program:** Provide the **name** of the institution your residency program is accredited under, the city and state of location.
- **Practice/Training Authorization:** Provide your medical license number, educational permit number or other proof that you are authorized to practice medicine in your out-of-state residency program. If a license or permit number is not available, please contact the Board.
- **Proof of Identity:** Submit a clear and legible copy of your valid, government-issued identity document bearing your legal name, date of birth and photograph. Accepted documents include:
    - A driver's license or non-driver identification card;
    - A passport or U.S. Global Entry identification card; or
    - A military or national identification card.
- **Application Fee:** The application fee is $50. Please do not include the nonrefundable 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.

Provide your <u>original</u> application, with Section A completed, to your West Virginia Rotation Program Director for completion of Section B.

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SECTION B: To Be Completed by the West Virginia Rotation Program Director/Designee

1. **After** the permit applicant completes Section A, please complete Section B.
2. The West Virginia Rotation Program Director may designate one individual to complete the application on his or her behalf. To make such designation, the West Virginia Rotation Program Director must submit an original signed letter to the Board which identifies the full name and title of the designated individual.
3. By certifying the content of the application, you are verifying that the applicant is an authorized participant in the out-of-state ACGME accredited program identified in Section A.
4. Before completing Section B of the application, please review the following instructions:
    - **Rotation Program Name and Address:** Provide the name and address of the institution providing the West Virginia rotation training.
    - **Specialty/Subspecialty:** Provide the name of the specialty program for the West Virginia rotation (example: Internal Medicine).
    - **Mailing Address:** Provide the mailing address of the West Virginia rotation training program. This address, along with the name of the postgraduate program and the training specialty will be published on the Board's website.
    - **Training Level:** Identify the appropriate training level (example: PGY 1, 2, or 3) for the permit period. Reciprocal permits are limited to one 60-day period per academic year.
    - **ACGME:** Identify whether the West Virginia rotation training is ACGME approved.
    - **Rotation Training Dates:** Provide the start date and end date for the rotation. Reciprocal permits are limited to a consecutive 60-day period.
    - **Verification:** Certify that the applicant is eligible for a reciprocal educational permit. Affix the institutional seal to the application form. If a seal is not available, the form may be notarized. All applications must contain original signatures in Sections A and B. Notarized applications must also contain an original signature in the Notary section.

Submit the complete original application and identity document to the Board. If the Board issues a permit, the applicant and the rotation program will be notified using the email addresses provided in the application.

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

LIMITED TIME RECIPROCAL EDUCATIONAL PERMIT APPLICATION

SECTION A: To Be Completed By Applicant

Applicant Name: _____, MD
First Middle Last

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

Email Address: _____ **Home Phone:** _____

Home Address: _____
(Physical address – not a PO Box) City State Zip

Preferred Mailing Address: _____
City State Zip

Out-of-State Residency Program Name: _____

_____
City State

Practice/Training Authorization (License No./Permit No./Other): _____

I DECLARE THAT the information I have provided in Section A is true and correct. I understand that my practice in West Virginia pursuant to a reciprocal educational permit is limited to the location and scope of my temporary West Virginia residency rotation. I understand that I have a duty to notify the Board if any of the information in Section A changes.

Applicant's Original Signature: _____ **Date:** _____

SECTION B: To Be Completed By West Virginia Rotation Program Director

Rotation Program Name: _____ **Specialty/Subspecialty:** _____

Mailing Address: _____, **WV** _____
City Zip

Training Level: PGY_____ (e.g., 1, 2, 3) **ACGME:** ☐ Yes ☐ No

Rotation Period Starts: _____ (mm-dd-yyyy) **Rotation Period Ends:** _____ (mm-dd-yyyy)

Rotation Program Director/Designee Certification (Designee letter must be on file with the Board.)

I CERTIFY THAT the foregoing is a true and complete statement of the record of the applicant. I certify that: (a) the applicant is under contract as a resident and is an active participant in good standing in the ACGME approved postgraduate clinical training program identified in Section A; and (b) the applicant holds the appropriate authorization to practice medicine and surgery in the state where the applicant's out-of-state training program is located.

Printed Name: _____ **Email Address:** _____

Original Signature: _____ **Date:** _____

Affix your institutional seal in the space below. If no institutional seal is available, you must have this form notarized.

Notary (if no institutional seal is available)

State of _____, County of _____

I certify that on the date set forth below, the Rotation Program Director identified in Section B personally appeared before me and that I identified the affiant by: (a) comparing his/her physical appearance with the affiant's identifying document photograph; and (b) comparing the affiant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the affiant on this

_____day of _____ 20_____.

Notary's Signature: _____ **My Commission Expires:** _____