State of West Virginia
Board of Medicine

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

PHYSICIAN ASSISTANT REINSTATEMENT APPLICATION

If your West Virginia Board of Medicine physician assistant license expired on March 31, 2025, you are eligible to apply for reinstatement of licensure through March 31, 2026. Beginning April 1, 2026, you must apply for re-licensure using the Initial Physician Assistant Licensure Application.

IMPORTANT INFORMATION

By law, you MUST keep this office apprised of any and all address changes that occur during your registration period, including changes to your email address.

To **AVOID** delay in licensure reinstatement, or continued **EXPIRATION** of your physician assistant license, answer each question legibly and accurately. Review the entire application to verify that each answer is correct and complete. Illegible or incomplete applications **will be returned**.

Provide complete information in each of your responses. If you answer "yes" to any of the professional practice, character and fitness questions, you must provide a written explanation for each "yes" response and produce all related documentation. Your application will be considered **INCOMPLETE** if you do not provide the required explanations and documentation.

Your personal certification of accuracy and your original, dated signature is required in four different places on this application. Please review your responses carefully and make sure that you have signed and dated the application in all of the required locations. Because your original signature is required, applications are not accepted via facsimile or email.

Please keep a copy of your complete application for your records.

The expiration of your license also terminated any practice notifications which were active when your license expired. Prior to resuming physician assistant practice, and in addition to obtaining reinstatement of licensure, you must file a new practice notification with the Board and receive written authorization from the Board to commence practice.

APPLICATION INSTRUCTIONS

1. Please review these instructions carefully.

2. The West Virginia Board of Medicine requires applicants to personally complete their application. Any errors, omissions or misstatements are solely the responsibility of the applicant.

3. Complete the reinstatement application and return it to the Board office. The reinstatement application fee is $225. Please do not include the $225 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.

4. In association with the reinstatement application, you must submit documentation supporting successful completion of the required continuing education.

5. If you have prescribed or dispensed controlled substances pursuant to a West Virginia physician assistant license since April 1, 2023 and have been registered with the West Virginia Controlled Substances Monitoring Program (CSMP) Database, you must submit a copy of your CSMP Certificate of Registration with your reinstatement application.

6. Applications and fees are valid for six months. Applications which fail to complete within six months expire. Thereafter, a new application and fee are required to pursue relicensure.

7. Applications are subject to a continuous supplementation obligation. If any information changes during the application process (i.e. after you start the process and before a licensure decision is rendered) you are obligated to update any and all application components affected by the change in information.

8. Some relicensure applicants with unusual application circumstances may be required to meet with the Physician Assistant Committee of the Board in advance of licensure consideration.

9. Some information in your application file is considered public information. Such information includes, but is not limited to your: identity; age (not date of birth); physician assistant program; graduation date; malpractice history; disciplinary history; city and state of residence; and current work locations.

Mail your completed application with all documentation to:

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

APPLICATION FOR REINSTATEMENT OF PHYSICIAN ASSISTANT LICENSURE
(For the license period ending March 31, 2027)

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

WVBOM License #: _____ **Date of Birth:**_____ **Social Security No.: XXX-XX-**_____ **Sex:** _____

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:** _____

NCCPA Certification Status - Are you certified by the National Commission on the Certification of Physician Assistants (NCCPA)? **Yes ____ No ___**

If Yes, please provide your **Certificate Number**: _____ and **Expiration Date**: _____

Physician Assistants who do not hold current NCCPA certification must use the professional designation of "PA" and not "PA-C"

Practice Information - For the period of April 1, 2023 through today, please list each and every state and/or Canadian Province where you have been licensed, whether such license is currently active or not.

_____

_____

Workforce Planning Data - The Board is required by law to collect this data. If you are unsure of your retirement date, please provide your best estimate. The Board cannot process your application if you do not complete this section.

Will you be actively practicing in West Virginia? Yes ☐ No ☐

Anticipated date of retirement (year): _____

Percentage of time in direct services: _____

Percentage of time in administration: _____

Physician Assistant License Reinstatement Application – Page 2

Name:_____

Certification of Continuing Education Compliance – Include your CE certificates and drug diversion training and best practice prescribing of controlled substance training certificate with your application. If the CE certificates are not included, you will not be eligible to reinstate.

A. Mandatory Risk Assessment and Responsible Prescribing of Controlled Substances Training or Drug Diversion Training and Best Practice Prescribing of Controlled Substances Training. <u>You must select one.</u>

☐ Between April 1, 2023 and today, I completed a minimum of 3 hours of drug diversion training and best practice prescribing of controlled substances CME through a course which has been approved by the West Virginia Board of Medicine. I attest that I have reviewed the list of Board approved courses on the Board's website, and that the course I took is on the list and was completed between April 1, 2023 and today.

<u>OR</u>

☐ Between April 1, 2023 and today, I have not completed a minimum of 3 hours of drug diversion training and best practice prescribing of controlled substances CME through a course which has been approved by the West Virginia Board of Medicine. I attest that during the period of April 1, 2023 through today, I did not prescribe, administer, or dispense any controlled substance pursuant to a West Virginia license. I therefore request that the Board waive this specific 3-hour CME requirement,

<u>OR</u>

☐ Between April 1, 2023 and today, I have not completed a minimum of 3 hours of drug diversion training and best practice prescribing of controlled substances CME through a course which has been approved by the West Virginia Board of Medicine. I attest that my initial physician assistant license was issued by the West Virginia Board of Medicine less than one year ago, and I will complete this specific 3-hour required course within one year of my date of initial licensure.

B. Other Continuing Education for the Period of April 1, 2023 Through the Present. <u>You must select one.</u>

☐ I hereby attest that between April 1, 2023 and today, I have successfully completed a minimum of 100 hours of continuing education satisfactory to the Board. A minimum of 50 hours were designated as Category I CME by either the American Medical Association, American Academy of Physician Assistants or the Academy of Family Physicians. The remaining 50 hours were designated as either Category I CME or Category II CME by the entities listed above. I understand that if I am ineligible for a waiver of the mandatory drug diversion training and best practice prescribing of controlled substances training CME, I can include that course in my 100-hour CE total.

<u>OR</u>

☐ I hereby attest that in addition to either completing the mandatory drug diversion training and best practice prescribing of controlled substances CME or requesting a waiver of that requirement, between April 1, 2024 and today, I obtained a master's degree from an accredited program of instruction for physician assistants.

<u>OR</u>

☐ I hereby attest that in addition to either completing the mandatory drug diversion training and best practice prescribing of controlled substances CME or requesting a waiver of that requirement, between April 1, 2023 and today I have sat for and passed a recertification examination of the NCCPA, and I have requested that the NCCPA send my Score Report to the West Virginia Board of Medicine.

Continuing Education Attestation – I hereby attest that I have provided a true and accurate certification of my continuing education. I have enclosed either copies of certificates of CE completion, or other evidence of CE compliance as described in the section selected above.

Original Signature: _____ **Date:**_____

Physician Assistant License Reinstatement Application – Page 3

Name:_____

Professional Practice, Character and Fitness Questions – During the period of April 1, 2023 through today, have you, in any jurisdiction, for any reason:

		Yes	No
1	been called before or appeared before any board or panel for discussions or questions concerning violations of the law or rules pertaining to your practice as a physician assistant, or for unethical conduct?		
2	been charged with or convicted of or pled nolo contendere to any felony or misdemeanor? If your answer is yes, submit with your application certified copies of all court records related to any such charges, pleas and/or convictions.		
3	been charged with or convicted of a violation of the Controlled Substance Act or any other federal, state or local law pertaining to the manufacture, distribution, prescribing, or dispensing of controlled substances? If your answer is yes, submit with your application certified copies of all court records related to any such charges, pleas and/or convictions.		
4	had limitations, restrictions or conditions placed upon your certificate or license to practice, or had your certificate or license to practice suspended, revoked or subjected to any kind of disciplinary action, including censure, reprimand or probation, and/or are any disciplinary actions pending against you?		
5	voluntarily surrendered (not expired) or limited your certificate or license to practice?		
6	had any hospital privileges limited, restricted, suspended, revoked or subjected to any kind of disciplinary action, including censure, reprimand or probation? If your answer is yes, you must have the facility submit directly to the Board prior to reinstatement of licensure all documentation related to your answer.		
7	voluntarily resigned from any medical staff or voluntarily limited such staff privileges while under investigation by any health care institution or committee thereof or prior to any final decision by a hospital or health care facility's governing board?		
8	been denied the right to take an examination for certification or licensure in any state, or been ejected from any physician assistant examination?		
9	been denied certification or licensure to practice as a physician assistant?		
10	had your DEA registration restricted or removed?		
11	been convicted of Medicare or Medicaid fraud, and/or received any sanctions, including restriction, suspension or removal from practice imposed by an agency of the federal or state government?		
12	had any judgments or settlements arising from medical professional liability rendered or made against you between April 1, 2023 to present? For each medical professional liability settlement or judgment you report, please provide: (1) the name of the patient(s) alleging medical professional liability; (2) the date of loss; (3) the date of settlement or judgment; (4) the amount of the settlement or judgment against you; (5) the name of the insurance company providing coverage to you with respect to this claim; and (6) a brief description of the allegations and a summary of the care provided. Your application is incomplete until all of the requested information is submitted for each settlement and/or judgment.		
13	been addicted to, or received treatment for the use or misuse of, prescription drugs and/or illegal chemical substances, or been dependent upon alcohol or received treatment for alcohol dependency? (You may answer "no" if you are a participant in a written voluntary agreement with the West Virginia Medical Professionals Health Program, Inc., the West Virginia Board of Medicine designated physician health program.) If you answer yes and have gone through a rehabilitation program during the time frame designated above, you MUST have that program furnish this Board a report of your treatment and progress.		
14	had any interruption in your practice of medicine which might reasonably be expected by an objective person to currently impair your ability to carry out the duties and responsibilities of the physician assistant profession in a manner consistent with standards of conduct for the profession?		
15	had anything occur which might reasonably be expected by an objective person to currently impair your ability to carry out the duties and responsibilities of the physician assistant profession in a manner consistent with the standards of conduct for the profession?		

Professional Practice, Character and Fitness Attestation – All of my responses to the questions on this page are truthful and complete. If I have "yes" responses, I have enclosed written explanations, with my original dated signature for each question, and I have enclosed or caused to be submitted all requested supporting documentation.

Original Signature: _____ **Date:**_____

Name:_____

Proof of Controlled Substance Monitoring Program Registration – All physician assistants who prescribe or dispense and Schedule II, III, IV and/or V controlled substances pursuant to a West Virginia license are required to be registered with the West Virginia Controlled Substance Monitoring Program (CSMP). This is not the same as a DEA registration, and is obtained through the West Virginia Board of Pharmacy at https://www.csappwv.com.

Please check the box that is applicable to you. You must select one.

☐ I am currently registered with the CSMP, and the date of registration as it appears on my CSMP registration certificate is:_____/_____/_____.(mm/dd/yyyy)

☐ I am not currently registered with the CSMP, but I understand that if I intend to prescribe or dispense any controlled substances pursuant to my West Virginia physician assistant license, I must be registered to access the WVCSMP within 30 days of receipt of any physician assistant license issued pursuant to this application.

CSMP Attestation – I hereby attest that I have provided a true and accurate certification of my CSMP registration status.

Original Signature: _____ **Date:**_____

Child Support – The following certification is required by state law, and "making a false statement may subject the license holder to disciplinary action including, but not limited to, immediate revocation or suspension of the license." West Virginia Code §48-15-303. If you answer "yes" to any of the below questions, and if further information is needed, you will be notified.

I certify, under penalty of false swearing, that:

		Yes	No
1.	I have a court ordered child support obligation.		
2.	I have a court ordered child support obligation and any arrearage amount equals or exceeds the amount of child support payable for six months.		
3.	I am the subject of a child support related subpoena or warrant.		

Application Certification

I understand that I am required to personally complete this application, and I am solely responsible for the accuracy and completeness of the information provided, including all information regarding my practice since April 1, 2023, and my certification of successful completion of all required continuing education.

I understand that prior to dispensing or administering any controlled substances, including samples in an office-based setting, I must be registered with the Board as a controlled substance dispensing practitioner for each of my controlled substance dispensing locations.

I have carefully read and understood all the questions included on each page of this reinstatement application and have answered all the questions completely, without reservations of any kind. I declare that my answers and all statements made by me herein are true and correct.

I understand that any license issued based upon this reinstatement application is based on the truth of the statements contained herein. Should I furnish false or misleading information in this reinstatement application, I hereby agree and understand that any such act shall constitute good cause for disciplinary action and/or the subsequent revocation of my license.

I understand that regardless of the date of my signatures, all statements in this reinstatement application relate to the entire period of April 1, 2023 to present. If, after I provide my signature and prior to reinstatement of licensure, any answer should change for any reason, I have a duty to notify the Board and amend my reinstatement application.

I understand that prior to resuming physician assistant practice, and in addition to obtaining reinstatement of licensure, I must file a new practice notification with the Board and receive written authorization from the Board to commence practice.

Original Signature: _____ **Date:**_____