State of West Virginia
Board of Medicine

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

ALLOPATHIC EDUCATIONAL PERMIT INSTRUCTIONS AND APPLICATION

The Board only accepts applications which are complete, legible, contain personal signatures in Sections A and B, and are accompanied by a copy of your proof of identity document.

SECTION A: To Be Completed by Applicant

- **Name:** Provide your legal name. Your name on the application must be your legal name 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. You must provide a valid email address. This is how the Board will provide your permit and communicate with you. You may write "same" if your preferred mailing address is your home address. Please contact the Board office if your contact information changes.
- **Date of Graduation:** Provide your **medical school graduation date** as it appears on your diploma. **The only time you should enter a future date is if you have not yet graduated from medical school.** If you are providing an **anticipated date of medical school graduation**, and the graduation date you have provided changes for any reason, you must notify the Board immediately.
- **ECFMG:** If you graduated from a medical school outside of the United States, Puerto Rico, or Canada you must provide your ECFMG identification number.
- **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 $100. 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 application, with Section A completed, to your program for completion of Section B.

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SECTION B: To Be Completed by Program Director/ Designee

1. After the permit applicant completes Section A, please complete Section B.
2. The program director may designate one individual to complete the application on his or her behalf. To make such designation, the 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 will not commence training until the program has proof of the applicant's medical school graduation.
4. Before completing Section B of the application, please review the following instructions:
    - **Postgraduate Program and Address:** Please provide the name of the institution providing graduate medical training.
    - **Specialty/Subspecialty:** Please provide the name of the specialty program (example: Internal Medicine).
    - **Mailing Address:** Please provide the mailing address of the applicant's 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:** Please identify the appropriate training level (example: PGY 1, 2, or 3) for the permit period. *(Educational permits expire on June 30th of every year.)* If the applicant is off cycle and will be in multiple training levels during the permit period, please explain on the application.
    - **Training Type:** Identify whether the training is residency training or a fellowship. For fellowship training, the program director must verify that prior to fellowship training the applicant has completed an ACGME-approved residency program, or a residency program recognized by the ECFMG.
    - **ACGME:** Please identify whether the training is ACGME approved.
    - **Training Contract Dates:** Provide the start date and end date of the contract period for the applicant's current PGY training year (example: July 1, 2024 through June 30, 2025).
    - **Verification:** Your personal signature (i.e. not an electronic signature) certifies that the applicant is eligible for an education permit.
    - **Seal/Notarization:** Affix the institutional seal in the space provided. If no seal is available, the program director/designee will need to sign Section B in the presence of a notary.

Submit the complete application and a copy of the applicant's identity document to the Board. If the Board issues a permit, the applicant and program will be notified via email at the email addresses provided on the application.

WEST VIRGINIA BOARD OF MEDICINE
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2024 APPLICATION FOR ALLOPATHIC EDUCATIONAL PERMIT

SECTION A: To Be Completed By Applicant

Applicant Name: _____
First Middle Last Suffix

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

Email Address: _____ **Cell/Home Phone:** _____

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

Preferred Mailing Address: _____
City State Zip

Medical School of Graduation: _____

City: _____ **State:** _____ **Country:** _____

Date/Anticipated Date of MEDICAL SCHOOL Graduation**:** _____(mm-dd-yyyy) **ECFMG No.** (if applicable)**:** _____

I DECLARE THAT the information I have provided in Section A is true and correct. I understand that I have a duty to notify the Board if any of the information in Section A changes.

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

SECTION B: To Be Completed By Program Director / Designee

Postgraduate Program: _____ **Specialty/Subspecialty:** _____

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

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

Training Contract Starts: _____(mm-dd-yyyy) **Current PGY Year Ends:** _____(mm-dd-yyyy)

I, the Program Director or duly authorized Designee, CERTIFY THAT the foregoing is a true and complete statement of the record of the applicant. I certify that the applicant shall not commence training until the program verifies that the applicant has: (a) graduated from an allopathic medical school approved by the LCME; (b) met the requirements for certification by the ECFMG; or (c) has completed an alternate pathway for initial entry or transfer requirements by the ACGME. If this application is for fellowship training, I also certify that prior to commencing fellowship training the applicant has/will complete an ACGME-approved residency program or a residency program recognized by the ECFMG. (If this section is signed by a duly authorized Designee, a current designee letter must be on file with the Board.)

Printed Name: _____ **Email:** _____

Signature: _____ **Date:** _____

Affix your institutional or notarial seal in the space below.

Notary (if no institutional seal is available)

State of _____, County of _____

I certify that on the date set forth below, the Signatory 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:** _____