State of West Virginia
Board of Medicine

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

2024 RENEWAL INSTRUCTIONS FOR ALLOPATHIC EDUCATIONAL PERMITS

The Board only accepts applications which are: complete; legible; and contain signatures in Sections A and B.

SECTION A: TO BE COMPLETED BY APPLICANT	SECTION B: TO BE COMPLETED BY PROGRAM DIRECTOR/DESIGNEE
1. Provide your full name and educational permit number. If your legal name has changed since you received an educational permit from the Board, you must provide evidence of your legal name change.	**5.** Verify the program, specialty, training level and training type of the applicant.
2. Provide your current contact information. You must provide a current phone number and email address for your application to be complete.	**6.** If the applicant is off cycle, and will be in multiple training levels during the permit period, or will complete training prior to June 30, 2025, please explain on the application.
3. Sign and date Section A.	**7.** Certify that the applicant remains under contract with the program and is currently an active participant in good standing.
4. After you complete Section A, provide your renewal application to your program director for completion of Section B.	**8.** Sign and date Section B.
9. Submit your complete, original application to the Board. The application fee is $100. Please do not include the $100 nonrefundable renewal application fee with your application. The West Virginia Board of Medicine accepts online credit card payments for all fees. Upon receipt of your renewal application, the Board will send payment instructions via email.	

Once you successfully complete the renewal process, your renewed permit will be emailed to you and your program director/designee at the email addresses provided on the application.

WEST VIRGINIA BOARD OF MEDICINE
101 DEE DRIVE, SUITE 103, CHARLESTON, WV 25311
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2024 ALLOPATHIC EDUCATIONAL PERMIT RENEWAL APPLICATION

For the Period of July 1, 2024 to June 30, 2025

SECTION A: To Be Completed By Applicant

Applicant Name: _____
First Middle Last Suffix

Educational Permit Number: _____

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

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

Preferred Mailing Address: _____
City State Zip

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

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

SECTION B: To Be Completed By Program Director / Designee

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

Training Level: PGY_____ (e.g., 1, 2, 3) **Training Type:** ☐ Residency ☐ Fellowship

ACGME: ☐ Yes ☐ No

I, the Program Director or duly authorized Designee, CERTIFY THAT the above-named applicant remains under contract as set forth in W. Va. Code R. § 11-12-4.5.4 and is currently an active participant in good standing in the above-referenced program of post-graduate clinical training. (If this section is signed by a duly authorized Designee, a current designee letter must be on file with the Board.)

Office Phone: _____ **Email:** _____
(For receipt of Program's copy of renewal applicant's wallet card)

Program Director/Designee Printed Name: _____

Program Director/
Designee Original Signature: _____ **Date:** _____