State of West Virginia
***Board of Medicine***

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

# 2025 INTERSTATE TELEHEALTH REGISTRATION RENEWAL APPLICATION INSTRUCTIONS

**1.** Do not delegate completion of your interstate telehealth registration renewal application to any other person. Applications which are incomplete and/or illegible will be returned for correction and will not be processed by the Board.

**2.** Please include your printed name at the top of each page in the space provided. Make sure the contact information you provide is clear and complete. By law, you are required to notify the Board of all address changes that occur during your registration period, including updates to your email address.

**3.** Provide complete information in each of your responses. If you answer "yes" to any of the 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 explanation(s) and documentation.

**4.** Your personal certification of accuracy and your original, dated signature is required on this application. Please review your responses carefully and make sure that you have signed and dated the application. Because an original signature is required, the Board does not accept renewal applications via facsimile or email.

**5.** Please remember, that in addition to your interstate telehealth registration, physician assistants must also have an activated Practice Notification on file with the Board to practice as a physician assistant to West Virginia patients. Additional information concerning practice notifications is available on the at https://wvbom.wv.gov/practitioners/PA/PA_Forms.asp.

**6.** Mail the original completed renewal application, and any required supplemental documentation, to the Board at the address listed above. Please keep a copy of the application for your records.

**7.** The interstate telehealth registration renewal application fee is $175.00 for medical doctors and $50.00 for physician assistants. Do not include the renewal application fee with your renewal application. The Board accepts online credit card payments for all fees. **Upon receipt of your completed application, the Board will send payment instructions via email to the email address provided on the application.**

**The renewal application AND the renewal application fee must be received prior to 4:30 pm EDT on Monday, March 31, 2025 to avoid expiration. There is no grace period for practice if your registration expires.**

# Interstate Telehealth Registration Renewal Application

**(For the renewal period of April 1, 2025 to March 31, 2026)**

**Profession Type:** ☐ **Medical Doctor** ☐ **Physician Assistant**

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

**ITR Registration No:**_____ **Date of Birth:**_____ **Sex:**___ **Social Security Number:** xxx-xx-_____

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**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:** _____

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**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:** _____

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**Primary Work Address -** Your primary work address is publicly available on the West Virginia Board of Medicine website.

**Business Name (if applicable):** _____

**Street Address:**_____ **Telephone:** _____

**City:**_____ **State:**_____ **Zip Code:** _____ **County:** _____ **Fax:** _____

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**Practice Information:** For the period of April 1, 2024 through March 31, 2025, please list each and every state and commonwealth where you have been licensed, whether such license is currently active or not. If you need additional space, please use a separate sheet of paper.

| State | Status |
|---|---|
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Please provide complete and accurate answers to the following questions concerning your out of state licensure. For the purpose of these questions "professional license" means a license to practice medicine, podiatric medicine or as a physician assistant in any state or commonwealth of the United States.

ALL YES ANSWERS MUST BE ACCOMPANIED BY A WRITTEN EXPLANATION, SIGNED AND DATED BY YOU, EXPLAINING IN DETAIL YOUR YES ANSWER(S). YOU MUST ALSO ENCLOSE OR CAUSE TO BE SUBMITTED ALL REQUESTED SUPPORTIVE DOCUMENTATION.

| | Yes | No |
|---|---|---|
| 1. Do you have any limitations, restrictions or conditions placed upon any of your professional licenses by any medical board? | | |
| 2. Have you ever had a professional license revoked, suspended, or placed on probation? | | |
| 3. Have you ever surrendered a professional license? | | |
| 4. Have you had disciplinary action taken against your professional license(s) in any jurisdiction? | | |
| 5. Are you currently under investigation or subject to an administrative complaint in any jurisdiction related to your professional conduct or professional licensure? | | |
| 6. Are you out of compliance with the continuing education requirements in any of the states and/or commonwealths where you are licensed? | | |

## Acknowledgement / Certification

**By affixing my signature to this application, I attest:**

I have personally completed this interstate telehealth registration renewal application. I have read and understand each question included in the application. I understand that false or misleading information could result in action against my registration. My answers are true and complete. I will update this application if my answers should change for any reason prior to April 1, 2025.

**Original Signature:**_____ **Date:** _____

Mail the original completed application and any required supplemental documentation to:

West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, West Virginia 25311

**Do not include the renewal application fee with your application. The Board 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 this application.**