State of West Virginia
Board of Medicine

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

REINSTATEMENT APPLICATION INSTRUCTIONS FOR PHYSICIANS LICENSED IN WV THROUGH THE INTERSTATE MEDICAL LICENSURE COMPACT (IMLC) PROCESS

IMLC Pathway Licensees With Last Names That Begin With The Letters M-Z

If your West Virginia medical license was initially issued through the IMLC and expired on June 30, 2025, you may be eligible to apply for reinstatement of IMLC pathway licensure until June 30, 2026. The license you hold in your state of principal licensure must be active and in good standing to begin the reinstatement process. Alternatively, if you want to opt out of the IMLC process, you may submit an initial application for a traditional pathway license.

IMPORTANT INFORMATION FOR ALL APPLICANTS

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

To **AVOID** delay in licensure reinstatement, or continued **EXPIRATION** of your medical 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 form in all of the required locations. Because your original signature is required, applications are not accepted via facsimile or email.

Please do not delegate completion of the reinstatement application to any other person. Completion of the reinstatement application is solely the responsibility of the applicant.

Applications which fail to complete within six months will expire.

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

Mail your completed application to: **WEST VIRGINIA BOARD OF MEDICINE**
101 Dee Drive, Suite 103
Charleston, WV 25311

INSTRUCTIONS

1. Complete the reinstatement application and return it to the Board office. The application fee is $600. Please do not include the $600 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.

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

3. If you have prescribed or dispensed Schedule II, III, IV or V controlled substances pursuant to a West Virginia medical license since July 1, 2023, and have been registered with the West Virginia Controlled Substances Monitoring Database, you must submit a copy of your certificate of registration.

4. Following submission of your complete reinstatement application, the Board will request that the IMLC grant you access to reinstate with the IMLC through the portal entitled "**Renew**" on the IMLC website at https://www.imlcc.com/renew. You will then need to submit the IMLC renewal application and $25.00 fee.

5. You must complete this West Virginia Reinstatement Application and the IMLC "Renew" process and pay both the $600.00 reinstatement fee to this Board and the $25.00 renewal fee to the IMLC before you are eligible for license reinstatement in West Virginia. Reinstatement is not retroactive.

Medical Doctor License Reinstatement Application

(For the license period ending June 30, 2027)

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

License No.:_____ **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:**_____

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:**_____

Secondary Work Address (if applicable)

Business Name (if applicable):_____

Street Address:_____**Telephone:**_____

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

Medical Doctor License Reinstatement Application – Page 2

Name:_____

Practice Information - For the period of July 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.

_____

_____

Current Hospital Privileges - Please list all West Virginia hospitals where you currently have admitting privileges.

_____

_____

☐ I do not currently have admitting privileges at any West Virginia hospital(s).

Medical Corporation or Professional Limited Liability Company - Please list each medical corporation or professional limited liability company for which you are currently a shareholder, owner, member or partner.

_____

_____

☐ I am not a shareholder, owner, member or partner of a medical corporation or a professional limited liability company.

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 medicine in West Virginia? ☐ Yes ☐ No

Anticipated date of retirement (year): _____

Percentage of time in direct services: _____

Percentage of time in administration: _____

Specialty - Enter the code for your specialty. A list of specialty codes is provided with this application

Primary Specialty: _____ **Secondary Specialty (if applicable):** _____

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." W. Va. 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.		

Name:_____

Certification of Continuing Medical Education Compliance – If you are unable to certify compliance with the CME requirements, you are not eligible to reinstate. A list of Board approved courses which satisfy the mandatory risk assessment and responsible prescribing of controlled substances training / drug diversion training and best practice prescribing of controlled substances training is available at https://wvbom.wv.gov/2025CMECourses.asp. Include your CME certificates with your application. If your CME certificates are not included, you will not be eligible to reinstate.

A. Mandatory Risk Assessment and Responsible Prescribing of Controlled Substances Training / Drug Diversion Training and Best Practice Prescribing of Controlled Substances Training. Please select the option below that is applicable to you. You must select one.

☐ I hereby attest that between July 1, 2023 and today, I completed a minimum of 3 hours of risk assessment and responsible prescribing of controlled substances training / drug diversion training and best practice prescribing of controlled substances training 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 July 1, 2023 and today.

OR

☐ I hereby attest that during the period of July 1, 2023 through today, I did not and will not prescribe, administer, or dispense any controlled substances pursuant to my West Virginia license. I therefore request that the Board waive the risk assessment and responsible prescribing of controlled substances training / drug diversion training and best practice prescribing of controlled substances training CME requirement.

OR

☐ I hereby attest that my initial medical license was issued by the West Virginia Board of Medicine after July 1, 2024, and I will complete a minimum of 3 hours of risk assessment and responsible prescribing of controlled substances training / drug diversion training and best practice prescribing of controlled substances training through a course which has been approved by the West Virginia Board of Medicine within one year of my date of initial licensure.

B. Other Continuing Medical Education for the period of July 1, 2023 through the present. Please select the statement below that describes how you satisfied your CME obligation for the identified reporting period. You must select one.

☐ I hereby attest that between July 1, 2023 and today, I have successfully completed a minimum of 50 hours of continuing medical education satisfactory to the Board. All courses for which I claim credit have been designated as Category I CME by the AMA or the AAFP. Thirty hours of courses for which I claim credit are within my designated area(s) of specialty. I understand that I cannot claim more than 20 hours of medical teaching/preceptorship towards my 50-hour total. I understand that if I am ineligible for a waiver of the mandatory risk assessment and responsible prescribing of controlled substances training / drug diversion training and best practice prescribing of controlled substances course, I can include that course in my 50-hour total.

OR

☐ I hereby attest that between July 1, 2023 and today, I sat for and passed a certification or recertification examination of an American Board of Medical Specialties member board and received certification or recertification.

OR

☐ I hereby attest that I am American Board of Medical Specialties certified, and between July 1, 2023 and today, I have been successfully involved in maintenance of certification.

OR

☐ I hereby attest that between July 1, 2023 and today, I have successfully completed one full year of ACGME approved post-graduate training.

Continuing Medical Education Attestation – I hereby attest that I have provided a true and accurate certification of my continuing medical education. Additionally, I have enclosed with my application either copies of certificates or other evidence of CME compliance as described in the section above.

Original Signature:_____ **Date:**_____

Name:_____

Professional Practice, Character and Fitness Questions – During the period of July 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 the practice of medicine, 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 license to practice by a medical board, or had your license to practice suspended, revoked or subjected to any kind of disciplinary action, including censure, reprimand or probation by a medical board, and/or are any disciplinary actions pending against you?		
5.	voluntarily surrendered (not expired) to a medical board or limited your medical license with a medical board?		
6.	had any hospital privileges, and/or postgraduate training, 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 your license 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 licensure in any state or been ejected from any medical examination?		
9.	been denied a license to practice medicine?		
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 July 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 judgement 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 medical profession in a manner consistent with standards of conduct for the medical 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 medical profession in a manner consistent with the standards of conduct for the medical 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 physicians who prescribe or dispense Schedule II, III, IV and/or V controlled substances pursuant to a West Virginia license are required to be registered with the West Virginica Controlled Substance Monitoring Program (WVCSMP). 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 Schedule II, III, IV and/or V controlled substances pursuant to my West Virginia medical license, I must be registered to access the WVCSMP within 30 days of receipt of any medical 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. I have enclosed a copy of my CSMP registration if applicable.

Original Signature: _____ **Date:**_____

Application Certification

I understand that as the applicant, 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 July 1, 2023, and my certification of successful completion of all required continuing medical education.

I understand that prior to dispensing or administering any controlled substances, including free 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 licensure.

I understand that regardless of the date of my signatures, all statements in this reinstatement application relate to the entire period of July 1, 2023 to the 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 after submitting this reinstatement application, I will be granted access to the IMLC license portal entitle "**Renew**" in order to complete the IMLC renewal application and remit the required IMLC renewal fee directly to the IMLC. The IMLC will confirm to the Board that my West Virginia license has been reinstated with the IMLC.

I understand that by submitting this application, I am seeking reinstatement of West Virginia licensure through the IMLC licensing process, and that any license I receive pursuant to this application will be a license which is subject to the terms, conditions and laws of the Interstate Medical Licensure Compact Commission.

Original Signature: _____ **Date:**_____