



State of West Virginia *Board of Medicine*

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

PODIATRIC PHYSICIAN LICENSE CHANGE OF STATUS APPLICATION

Your license to practice podiatric medicine in the State of West Virginia is an **INACTIVE** status. Licensees who seek to change licensure status from INACTIVE to ACTIVE status must submit a complete Change of Status Application with all required accompanying documentation and pay the \$400 application fee.

IMPORTANT

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

To **AVOID** delay in licensure activation, 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** to the applicant.

Complete the Change of Status Application and return it to this office. The change of status application fee is \$400. Please do not include the 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 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 the required locations. Because your original signature is required, applications are not accepted via facsimile or email.

Please do not delegate completion of this 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.

In association with the application, you must submit:

1. A letter accounting your professional activities for your period of inactivity beginning with the date your West Virginia license became inactive. Your explanation of your activities must be satisfactory to the Board.
2. Documentation supporting successful completion of the required continuing podiatric education **during the period of July 1, 2023 through June 30, 2025**.
3. A copy of your West Virginia Board of Pharmacy Controlled Substances Monitoring Program Database Certificate of Registration (if applicable).

Mail your completed application to:

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

Podiatric Physician License Change of Status 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: _____

Licensure Status – Change from inactive to active:

☐ **Active Status** (\$400.00 Change of Status fee)

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:** _____

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Name: _____

Practice Information - For the period of July 1, 2023 through present, 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/Podiatric Corporation or Professional Limited Liability Company - Please list each medical/podiatric 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/podiatric 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 podiatric 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.

Codes for self-designation of practice specialty / area of practice:

FOR – Foot Orthopedics or Biomechanics

PGR – Podogeriatrics

S – Surgery

GP – General Practice

PPD – Podopediatrics

OS – Other Specialty

PD – Podiatric Dermatology

ROE – Roentgenology

NS – No Specialty

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.” 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.		

Name: _____

Certification of Continuing Podiatric Education Compliance – Responses shall be for the period July 1, 2023 to June 30, 2025. 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 CPE certificates or other evidence of your CPE completion with your application. If you have questions, please contact the Board office at (304) 558-2921.

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

☐ Between July 1, 2023 and June 30, 2025, I completed a minimum of three (3) hours 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 June 30, 2025. I have enclosed evidence of course completion.

OR

☐ I attest that during the period of July 1, 2023 through June 30, 2025, I did not prescribe, administer, or dispense any controlled substance pursuant to a 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 CE requirement.

B. Other Continuing Podiatric Education for the Period of July 1, 2023 Through June 30, 2025
You must select one.

☐ I hereby attest that between July 1, 2023 and June 30, 2025, I have successfully completed a minimum of fifty (50) hours of continuing podiatric education satisfactory to the Board. All courses for which I claim credit have been approved by the APMA or Council on Podiatric Medical Education; were presented or sponsored by any of the podiatry colleges in the United States; are designated as Category I by the AMA or AAFP; or were presented or sponsored by the West Virginia Podiatric Medical Association. 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 podiatric or 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. I have enclosed evidence of CPE completion.

OR

☐ I hereby attest that between July 1, 2023 and June 30, 2025, I have successfully completed one full year of graduate training approved by the Council on Podiatric Medical Education or the Colleges of Podiatric Medicine, and I can provide written verification from my program.

OR

☐ I hereby attest that between July 1, 2023 and June 30, 2025, I sat for and passed a certification or recertification examination of the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery and received certification or recertification from the said board during the reporting period. I have enclosed a copy of my certification or recertification certificate.

CPE 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 CPE completion, or other evidence of CPE compliance as described in the section selected above.

Original Signature: _____

Date: _____

Podiatric Physician License Change of Status Application – Page 4

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 podiatric medicine, or for unethical conduct?		
2. been charged with or convicted of or pled nolo contendere to any felony or misdemeanor? <u>If your answer is yes, submit with your application certified copies of all court records related to any such charges, pleas and/or convictions.</u>		
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? <u>If your answer is yes, submit with your application certified copies of all court records related to any such charges, pleas and/or convictions.</u>		
4. had limitations, restrictions or conditions placed upon your license to practice by a medical/podiatric 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/podiatric board, and/or are any disciplinary actions pending against you?		
5. voluntarily surrendered (not expired) to a medical/podiatric board or limited your podiatric license with a medical/podiatric 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? <u>If your answer is yes, you must have the facility submit directly to the Board all documentation related to your answer.</u>		
7. voluntarily resigned from any medical/podiatric 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 podiatric examination?		
9. been denied a license to practice podiatric 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.) <u>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.</u>		
14. had any interruption in your practice of podiatric medicine which might reasonably be expected by an objective person to currently impair your ability to carry out the duties and responsibilities of the podiatric profession in a manner consistent with standards of conduct for the podiatric 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 podiatric profession in a manner consistent with the standards of conduct for the podiatric 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: _____

Podiatric Physician License Change of Status Application – Page 5

Name: _____

Proof of Controlled Substance Monitoring Program Registration – All podiatric physicians who prescribe or dispense Schedule II, III, IV and/or V controlled substances pursuant to a West Virginia license are required to show proof that they are 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 I have enclosed a copy of my CSMP registration certificate.

☐ 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 podiatric license, I must be registered to access the WV CSMP within thirty (30) days of a change in my license status from inactive to active.

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 certificate, if applicable.

Original Signature: _____

Date: _____

Application Certification

I understand that as a licensee, 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, 2025 and my certification of successful completion of all required continuing podiatric 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 change of status 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 change of status application is based on the truth of the statements contained herein. Should I furnish false or misleading information in this change of status 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 change of status application relate to the entire period of July 1, 2025 to present. If, after I provide my signature and before the Board converts my license to active status, any answer should change for any reason, I have a duty to notify the Board and amend my application.

Original Signature: _____

Date: _____