



State of West Virginia

Board of Medicine

101 Dee Drive, Suite 103
Charleston, WV 25311
Telephone (304) 558-2921
Fax (304) 558-2084
www.wvbom.wv.gov

UNIVERSAL PROFESSIONAL AND OCCUPATIONAL LICENSING ACT OF 2025 PHYSICIAN ASSISTANT APPLICATION INSTRUCTIONS

Thank you for your interest in obtaining a physician assistant (PA) license in the State of West Virginia. It is our goal to assist qualified, eligible candidates in obtaining licensure in this state as efficiently and expeditiously as possible.

There are two primary pathways for PA licensure in West Virginia: (1) the traditional licensure pathway; and (2) the Universal Professional and Occupational Licensing Act of 2025 (UPOLA") pathway.¹ Information on the traditional pathway is available on the Board's website. These instructions are intended for applicants who seek to utilize the UPOLA pathway for initial PA licensure.

Prerequisites to Utilize UPOLA Pathway

To utilize the UPOLA pathway, applicants must either:

1. Establish residency in the state of West Virginia;

OR

2. Be married to an active-duty member of the armed forces of the United States and have accompanied the member to an official permanent change of station to a military installation located in West Virginia.

Applicants who do not meet either of these criteria are ineligible to use the UPOLA pathway, and are invited to apply through the traditional pathway, if eligibility criteria are met.

¹ Pursuant to W. Va. Code § 30-1-27, a person shall be granted an occupational or professional license, registration, or certificate if the person has been licensed or certified in another state, the license, registration, or certificate is in the same discipline and at the same practice level as the license, registration, or certificate for which the person is applying in this state and the person meets other conditions prescribed by W. Va. Code § 30-1-27.

Additional Eligibility Requirements for PAs
Who Meet Prerequisites to Utilize UPOLA Pathway

PAs who have established West Virginia residency or who are married to an active-duty member of the armed forces of the United States and have accompanied the member to an official permanent change of station to a military installation located in West Virginia must also satisfy the following additional minimum eligibility criteria to request licensure pursuant to the UPOLA pathway:

1. The applicant must be currently licensed, registered, or certified in at least one other state in the discipline applied for and at the same practice level as determined by the WVBOM;
2. The applicant's license, registration, or certification is in good standing in all states in which the applicant holds a license, registration, or certification;
3. The applicant is licensed, registered, or certified by another state with minimum education requirements and, if applicable, work experience and clinical supervision requirements in effect, and the other state verifies that the person met those requirements in order to be licensed, registered, or certified in that state;
4. The applicant previously passed any examinations, written or clinical, required for the license, registration, or certification if required by the other state;
5. The applicant has not had a license, registration, or certificate revoked or has not voluntarily surrendered a license, registration, or certificate in any other state or country while under investigation for unprofessional conduct;
6. The applicant has not had any other form of discipline imposed by any other regulating entity: *Provided*, that if another state's regulating entity has taken disciplinary action against the applicant, the Board may issue the license, registration, or certificate if it determines the cause of action in the other state was corrected and the matter fully resolved;
7. The applicant pays all applicable fees in this state; and
8. The applicant does not have a disqualifying criminal history.

A license issued by the Board pursuant to the UPOLA pathway provides the applicant with full practice authority in West Virginia. However, a UPOLA license:

1. May not form the basis of participation in the PA Licensing Compact; and
2. Because this pathway does not include verification of your PA education, the West Virginia Board of Medicine website cannot provide primary source verification of your education, Licensee profiles for UPOLA licensees will denote that education is not primary source verified.

GENERAL INSTRUCTIONS FOR UPOLA APPLICANTS

1. Please review these instructions carefully.
2. Prior to submitting your application and nonrefundable fee, confirm your eligibility for the license type you seek.
3. The West Virginia Board of Medicine requires applicants to **personally** complete the application and the WVBOM Photo Affidavit and Authorization for Release of Information. Any errors, omissions or misstatements are solely the responsibility of the applicant.
4. Applications are assigned to analysts for initial screening upon:
 - Submission of the paper application;
 - Payment of the license application fee (submitted online); and
 - Receipt of your original WVBOM Photo Affidavit and Authorization for Release of Information (original submitted by mail).
5. The analyst assigned to your application will send you a written status update upon initial screening, and periodically throughout the application process.
6. Any unusual circumstances or discrepancies in your application documents may require supplementation and/or other follow-up, and may increase the application processing time.
7. Applications which fail to complete within six months expire.
8. Applications are subject to a continuous supplementation obligation. If any information changes during the application process (i.e. after you start the process and before a licensure decision is rendered) you are obligated to update any and all application components affected by the change in information.
9. Licenses are issued within three business days of a determination that a complete application has been submitted by an eligible and qualified applicant and that the application does not contain unusual circumstances or discrepant information requiring personal review by the Board.
10. Applications which include discrepant information or unusual circumstances will be referred for review and recommendation at the next meeting of the PA Committee. Regular meetings occur in January, March, May, July, September, and November. Applications must complete ten days prior to a scheduled meeting to be included on the meeting agenda.
11. If warranted by information included in the application, and at the direction of the Committee, an applicant may be scheduled to meet with the PA Committee of the Board in advance of licensure consideration.
12. Some information in your application file is considered public information, including but not limited to your: identity (full name and other names); age (not date of birth); PA program and graduation date; malpractice history; disciplinary history; and current practice locations.
13. Please do not make legal commitments based upon your expectation of licensure and review your eligibility carefully. Not all applicants receive a license. License applications are not always complete within the anticipated timeframe. Neither applicants nor the Board can control the time frame in which third parties submit required documentation. The Board does not expedite one application in advance of another, nor does it issue a license if an application is incomplete, or if an applicant is ineligible.

INITIAL PA LICENSURE – UPOLA PATHWAY

To apply for initial PA licensure using the UPOLA pathway, please submit all of the following:

INITIAL LICENSE APPLICATION COMPONENTS
<p>1.a Evidence of eligibility – Establishment of West Virginia residence. To establish proof of West Virginia residence, please submit a legible color copy of your West Virginia driver's license or your West Virginia issued identification card.</p> <p>1.b. Evidence of eligibility – Applicants who are married to an active-duty member of the armed forces of the United States and have accompanied the member to an official permanent change of station to a military installation located in West Virginia should submit: (1) a certified copy of their marriage certificate; and (2) a complete and legible copy of their spouse's duty orders identifying the spouse's official permanent change of station to West Virginia.</p>
<p>2. Fingerprint-Based Criminal History Record Check. Fingerprinting services are provided by IdentoGo for a fee. The 6-digit service code for the West Virginia Board of Medicine is 228Q9Z. Complete instructions are available at: wvbom.wv.gov/Criminalhistory.asp. The Board is not permitted to utilize background checks performed for other entities. Background checks are valid for one year. The Board encourages you to start the background check process as soon as you submit Uniform Application.</p>
<p>3. WVBOM Photo Affidavit and Authorization for Release of Information. Complete and mail this original notarized form to the Board. The Board does not accept emailed or faxed copies of this document. This form is available for download during the online application process. In the upper right corner of page one, please write "UPOLA" so WVBOM staff are aware that you are utilizing the UPOLA pathway.</p>
<p>3. West Virginia Physician Assistant Application. The PA application is a paper form. In the upper right corner of page one, please write "UPOLA" so WVBOM staff are aware that you are utilizing the UPOLA pathway. Please complete the application and personally sign pages 5 and 6. The Board does not accept copies or digital signatures on initial license applications. Mail your original application to the Board.</p> <p>4.</p>
<p>5. Fee payment. Pay the nonrefundable application fee of \$250 online. 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. Please do not send payment with your mailed application.</p>
<p>6. License Verifications. Please have each and every state where you have been licensed to submit primary source verification of your licensure directly to the West Virginia Board of Medicine. Please check each Board's website for instructions on how to request licensure verification. If the license verification does not confirm all statutory requirements, additional information may be required. If so, you will be notified by the licensure analyst assigned to your application.</p>
<p>8.a Identity. Mail a copy of your birth certificate, passport, or certificate of naturalization to the Board. To protect your personally identifiable information, the Board does not accept identity documents via email. Applicants who establish residency by submitting a West Virginia driver's license or identification card do not need to submit an additional identification document.</p> <p>8.b. Name Change Documentation. If your current legal name does not match the name on any of your verifications, you must submit legal documentation supporting your name change. Licenses are issued utilizing current legal names.</p>

PA licenses issued pursuant to the UPOLA pathway are valid from issuance until the renewal deadline for PAs. Regardless of the date of initial license issuance, all PAs renew by March 31st in odd years. Thereafter, all eligible PAs may renew licensure for two-year intervals. Renewal requires the completion of all required Continuing Education. CE requirements for renewal are available on the WVBOM website.

WVBOM Photo Affidavit and Authorization for Release of Information

101 DEE DRIVE, SUITE 103, CHARLESTON, WEST VIRGINIA 25311

(304) 558-2921 wvbom.wv.gov

First: Middle: Last: Suffix:

Profession Type: ☐ MD ☐ DPM ☐ PA

Identifying Characteristics

Sex: ☐ Male ☐ Female

Height (ft.in): _____

Weight (lbs.): _____

Hair Color: _____

Eye Color: _____

Identifying Marks: _____

Date attached photo was taken: _____

(mm/dd/yyyy)

Applicant Photograph

Securely tape or glue a front-view 2" x 2" passport-type color photo of yourself in this square. Photo must be clear, accurately depict the applicant, and have been taken within 12 months of the date the Board receives this form.

**PHOTO MUST BE ATTACHED
PRIOR TO NOTARIZATION**

Authorization for Release of Application Status

The person(s) listed below have my permission to check on the status of my application for a West Virginia license. I understand that I may revoke this authorization, in writing, at any time during the application process. (If you do not want to authorize anyone else to receive status updates, please leave this section blank.)

Type or print name clearly

Type or print name clearly

Applicant's Signature: _____ **Date:** _____
(mm/dd/yyyy)

Notarized Affidavit and Authorization for Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Licensure Application I submitted to this Board and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

Continued on page 2

Continued from page 1

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant's printed legal name

Applicant's signature (must be signed in the presence of a notary)

Date (must be dated in the presence of a notary and correspond to date of notarization)

Notary

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

State of _____ County of _____ The statements
on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20_____.
Day Month Year

Notary Public Signature: _____

[Notary Seal]

My Notary Commission Expires: _____

Practice Information

Do you have proposed practice plans for West Virginia? YES ☐ NO

If yes, please describe your practice plans and proposed practice location:

Plans: _____ Location _____

Do your practice plans involve practice via telehealth? YES NO

Are you currently working as a provider? YES NO

If no, how long have you been absent from clinical practice? _____

FOR MDs AND DPMs ONLY

List your area of practice specialty: _____ Are you board certified? YES ☐ NO

If yes, please list your certifying board: _____

Mail original form to:
West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, WV 25311

West Virginia Board of Medicine

Physician Assistant License Application

101 DEE DRIVE, SUITE 103, CHARLESTON, WEST VIRGINIA 25311
(304) 558-2921 wvbom.wv.gov

Personal Information – In accord with federal law, please be advised that disclosure of your Social Security Number is MANDATORY in order for the Board to comply with the requirements of the federal National Practitioner Data Bank. Please be advised that contact information may be subject to release by the Board in response to a public records request.

Legal Name: _____
First Middle Last Suffix

Alternate Name(s): _____
First Middle Last (Maiden)

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

Please select the type of identity document you have enclosed with your application:

☐ Certified Birth Certificate ☐ Passport ☐ Certificate of Naturalization

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: _____

Preferred Mailing Address / Contact Information - Your preferred contact information, including your email address, is the information that the Board will use to contact you.

Business Name (if applicable): _____

Street Address: _____ Telephone: _____

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

Email Address: _____ Mobile Telephone: _____

Professional Education - Please enclose a legible copy of your diploma with your application. If you have not already done so, please submit the Physician Assistant Education Verification Form to your school for completion. Your school will return the form directly to the Board.

Name of PA School: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Degree Earned: _____ Date of Graduation: _____ (mm/dd/yyyy)

PA Initial License Application

Applicant Name: _____

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Examination and Certification

Date you passed the NCCPA's Physician Assistant National Certifying Examination (PANCE): _____

Please select the appropriate option regarding your current NCCPA certification status:

- ☐ I have never held NCCPA certification.
- ☐ I am currently certified by the NCCPA:
NCCPA Number: _____ Expiration Date: _____
- ☐ I am not currently NCCPA certified, but I am currently licensed in the following state that does not require maintaining NCCPA certification for licensure:

State: _____ License No.: _____ Expiration Date: _____

State Licensure History - If you have not already done so, please request verification of each of your licenses, regardless of current status. The verifying authority will submit your license verifications directly to the Board.

Have you ever been denied a license, certification or registration to practice in another jurisdiction?

- ☐ Yes ☐ No

Have you ever withdrawn a license, certification or registration application in another jurisdiction?

- ☐ Yes ☐ No

Have you ever had a physician assistant license, certification or registration suspended or revoked in any jurisdiction?

- ☐ Yes ☐ No

Licensure - Do you or have you ever held a license, certification or registration to practice in another jurisdiction?

- ☐ Yes ☐ No

Please list all licenses, certifications, or registrations you have received in all other states or jurisdictions, regardless of the current status of that license (i.e., active, inactive, lapsed, expired, revoked, suspended, surrendered, etc.) and list any state or jurisdiction in which you have ever applied for a physician assistant license, including those where your application is pending or was denied or withdrawn. If you need additional space, please continue your information on the Additional Licenses Chart included in your application packet. While not required, alphabetization by state is appreciated.

[illegible]

PA Initial License Application

Applicant Name: _____

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Chronology of Activity - List in chronological order all of your professional activities and/or places of employment since graduation from physician assistant school. This includes hospitals, teaching institutions, HMO's, private practice, corporations, military assignments, government agencies, locum tenens assignments, and employment outside of practice as a physician assistant. Also, include all periods of unemployment. If you need additional space, please continue your information on the Additional Chronology Chart included in your application packet. Please provide complete information. If you are a new graduate and have no professional activity after graduation, please check the new graduate box.

☐ I graduated from my PA program within the last 60 days and I have no chronology of activity to report at this time.

Begin Date (mm/dd/yy)	End Date (mm/dd/yy)	Employment / Practice Location Name <u>and</u> Address	Description of Activity (PA work, non-PA work, vacation, seeking employment, etc)

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.

PA Initial License Application

Applicant Name: _____

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Professional Practice, Character, and Fitness Questions - 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 PA practice, 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, 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 or limited your license to practice to a licensing board or equivalent authority?		
6	had any hospital privileges, 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 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 certification or licensure in any state, or been ejected from any physician assistant examination?		
9	been denied certification or licensure to practice as a physician assistant?		
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 professional liability rendered or made against you? 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 the settlement or judgement; (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 judgement.		
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, you MUST have that program furnish this Board a report of your treatment and progress.</u>		
14	had any interruption in your practice 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: _____

PA Initial License Application

Applicant Name: _____

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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.		

Application Certification

I understand that I am required to personally complete this application, and I am solely responsible for the accuracy and completeness of the information provided.

I have carefully read and understood the application instructions and all questions included on each page of this application, and I 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 the requirements and eligibility criteria for receipt of a physician assistant license, and agree that if I am unable to meet all these requirements, including the production of all required documents and materials, I will be denied licensure by the West Virginia Board of Medicine. I hereby certify that I am able to meet all these requirements for licensure in the State of West Virginia and that I will be able to produce all required documents and materials and that I will make no request of the Board for a waiver of any of the requirements, including the production of all required documents and materials. I understand that if I make any request for such a waiver, my request must and will be denied.

I understand that my application will not be considered until I produce all required application components. I understand that if this application is not completed within six (6) months my application will expire, and I must submit a new application to be considered for licensure in the future.

I understand that a license to practice as a physician assistant in West Virginia **does not** permit or authorize me to practice in this state until I have filed a proposed Practice Notification with the Board and I have received written authorization from the Board to practice in collaboration with physicians.

I understand that any license issued based on this application is contingent upon the truth of the statements contained herein. Should I furnish false or misleading information in this application, I hereby agree and understand that any such act shall constitute good cause for license denial and/or the subsequent revocation of my license.

I agree that I will supplement this application if any of my answers should change between now and when my application is considered for licensure.

Original Signature: _____

Date: _____

West Virginia Board of Medicine License Application Additional Licenses Chart

Applicant Name: _____

[illegible]

West Virginia Board of Medicine License Application Additional Chronology Chart

Applicant Name: _____

[illegible]