WEST VIRGINIA BOARD OF OSTEOPATHIC MEDICINE
405 Capitol Street, Suite 402
Charleston, WV 25301
(304) 558-6095 / Fax (304) 558-6096
www.wvbdosteo.org

APPLICATION FOR LICENSURE

INSTRUCTIONS

D.O. Application Process

The Federation of State Medical Boards

The Federation of State Medical Boards (FSMB) is a national non-profit organization representing the 70 medical and osteopathic boards of the United States and its territories, serving as the national resource and voice on behalf of these boards in their protection of the public.

Two services provided by FSMB that are often used by physicians when applying for licensure are the Federation Credentials Verification Service (FCVS) and the Uniform Application for Physician State Licensure (UA).

Please be aware that FCVS and the UA are two different services. The FCVS application is only used to establish a profile of credentials verified by primary sources. FCVS is not a licensure application. The UA is used as a licensure application most commonly by physicians applying to multiple state boards. Both services may be used when applying to a board for licensure. Check the board's instructions to determine if FCVS is required or accepted but not required.

Using the UA to Apply for Licensure

The Uniform Application is used to apply for licensure only, not for credentials verification. Once the UA has been completed and the one-time service charge has been paid, it can be updated and sent to other boards as needed. Additional information required by a board, but not covered in the core UA, is gathered by completing a state board specific UA addendum, various board or UA forms, and/or a board's online addendum or separate online application.

Applicants using the UA must account for all time since medical school graduation, including non-working time as well as postgraduate training and employment. Information on malpractice claims is also required. Having this information on hand before starting the UA is highly recommended.

To begin or update your UA, visit https://portal.fsmb.org/MyFsmb/ and click on the UA graphic, then sign in. You may also visit http://www.fsmb.org/ and click on Uniform Application in the Licensure menu to access the portal page.

Completing the UA

When completing your UA online, please complete all pages of the UA as instructed, noting the following:

- Refer to the state board to determine if entering your social security number is required.
- If not pre-filled, provide your home address and a separate address for business or postgraduate training. Both Board Contact and Public Access selections must be made but you can use the same address for each selection. All home addresses must be domestic, as fingerprint cards and other background information are mailed there.
- Enter each ACGME and/or AOA accredited training on the Accredited Training page. Enter all other training programs in the United States and Canada on the Other Training page.
- You are not able to add or edit MD or DO license information in the UA because that information is sent directly from the state boards into the FSMB system. If changes are needed, email ua@fsmb.org with the correct information. Depending on volume of license update requests, it may take 1-3 business days for the changes to appear in your UA. Do not enter MD or DO license information under "Other".
- Your Chronology of Activities should cover each of your activities (non-working time included) from medical school graduation to present. Previously listed medical school and postgraduate training programs will pre-fill the Chronology. Do not leave gaps. For each entry, use the first day of the month for start and end dates unless you know the exact date. If you have military or locum tenens assignments, list each location separately.
- Clinical time indicates time spent seeing patients and practicing medicine. Administrative time indicates time spent on paperwork, research, or teaching.
- Leave the signed malpractice liability claims section blank only if you have had no claims. List all pending claims.

- Upon accepting the Terms and Agreement and submitting the UA, first time UA users will be taken to a payment page for the one-time service charge. This charge sustains the UA program and is separate from FCVS and state board licensing fees.

- For a copy of your receipt, click on the "Home" link to return to the portal page, which will now have a Payment link to all FSMB receipts in the upper right corner.

- To open your UA for editing and resubmitting to a board, or for submitting to a new board, sign in and choose the appropriate board in the State Board section. Reselect the US Citizen query on the Identification page (it resets each time a UA is submitted), make changes as needed, then submit or resubmit your UA.

- Refer to the UA FAQ at https://www.fsmb.org/licensure/uniform-application/faq for answers to the most common UA questions. If your issue isn't listed, contact UA customer service at 800-793-7939 or email ua@fsmb.org with your username and a description of your issue. Provide a screenshot for each error you see.

In addition to completing the core UA online, applicants must:

- Unless otherwise noted in the board's instructions, submit a notarized UA Affidavit and Authorization for Release of Information form to the Board. The UA Affidavit is separate from the FCVS Affidavit and must be sent to the Board, not to FCVS or FSMB. Follow the instructions on the form.

- Unless otherwise noted in the board's instructions, have each full, temporary, training, or limited healthcare or profession license or certification you have ever held in the United States or Canada verified by the granting board, whether the license is currently active or inactive. To determine the fees and preferred verification method for each board, use the resource at http://www.fsmb.org/licensure/uniform-application/. If a board uses VeriDoc or other electronic format for verifications, do not use the UA verification form.

- Complete the FCVS initial or subsequent application if applicable.

- Complete all other board requirements as instructed.

Using FCVS for Credentials Verification

After a physician completes an initial FCVS application to establish a profile of verified credentials (documents related to identity, medical education, postgraduate training, etc.), FCVS staff contacts the primary source of each credential for verification. Each verified credential is added to a personalized profile created for the physician. Completed verifications are sent to each board designated to receive the profile during the application process.

After a physician completes a subsequent FCVS application, all new credentials are verified through primary sources. An updated profile is then sent to each board designated during the subsequent application process.

Each medical and osteopathic board in the United States and its territories (except for Puerto Rico) accepts or requires FCVS. Check the board's instructions to determine if FCVS is required or accepted but not required.

To begin an initial or subsequent application for creating or updating your profile, visit https://portal.fsmb.org/MyFsmb/ and click on the FCVS graphic, then sign in. You may also visit http://www.fsmb.org/ and click on FCVS in the Licensure menu to access the portal page. Please note: Designations to Self are for receiving your own copy of the profile. Boards do not accept Self designations.

For assistance, use the messaging tool in FCVS or call 888-275-3287 with your FCVS ID or nine-digit Federation ID (FID) between 8am and 5pm Central Time Monday through Friday.

BOARD APPLICATION CHECKLIST

	NOT using FCVS to verify credentials	Using FCVS to verify credentials
Completed online application (UA) and State Addendum	☐	☐
Completed State Addendum sent to Board.	☐	☐
Submit application fees as follows: 1. $400.00 to the Board 2. 2.25% processing fee to the Credit Card company 3. $125.00 Assessment Fee required by Senate Bill 602 passed by the 2016 Legislative Session	☐	☐
Submit an extra, recent (within 60 days) passport quality color photograph	☐	☐
As of January 1, 2017, all applicants must complete a Criminal Background Check.	☐	☐
Completed "Affidavit and Authorization for Release of Information" form submitted to the Board.	☐	☐
Use VeriDoc (www.veridoc.org) to process license verifications. If a board does not use VeriDoc, use the License Verification Form provided in this packet. • fill in the top portion with the pertinent information • copy and forward it to all states in which you are or have been licensed for them to complete and return to our office	☐	☐
Mail a signed Malpractice Liability Claims form(s) after completing malpractice section in the online UA.	☐	☐
Mail supporting documentation of name change (e.g. marriage certificate or divorce papers) to the Board. • Note: If your name has changed, and any of your licensure documentation (internship certificate, medical school diploma, other licensure certificates, etc.) shows a different name, you will need to provide documentation of this change (e.g. marriage certificate or divorce papers).	☐	Completed via FCVS
Medical Education Verification form (Form #2) sent to the Board by all medical schools attended. Download a Medical School Verification form • fill in the top portion with the pertinent information • copy and forward it to each medical school you have attended for them to complete and return to our office	☐	Completed via FCVS
A copy of your postgraduate training certificate(s) submitted to the Board.	☐	Completed via FCVS

(checklist continued on next page)

Postgraduate Training Verification Form sent to the Board from all programs you attended. Download a Postgraduate Education Verification form • fill in the top portion with the pertinent information • copy and forward it to each hospital where you participated in any postgraduate training program for them to complete and return to our office • provide documentation of completion of the first year of postdoctoral training (copy of intern certificate or letter from Director of Medical Education of program) • one year of clinical training must be in a program approved by the American Osteopathic Association, which may also include a program approved under the Association's Resolution 42 procedure; OR • postgraduate clinical training in a program approved by the ACGME and 40 hours of CME in osteopathic medicine with osteopathic manipulative treatment in courses approved, and classified as category 1A by the AOA (with at least 25% of those hours on hands-on osteopathic manipulation)	☐	Completed via FCVS
Examination Transcripts sent to the Board.	☐	Completed via FCVS

Upon the completion of the application file, the applicant will be notified to schedule a face to face interview with one of our Board Members. Our Board Members are located throughout West Virginia in Charleston, Vienna, Barboursville and Pine Grove for the applicant's convenience.

ADDENDUM TO APPLICATION

Applicant Name _____ **Date** _____

Please answer the following questions. **If you answer "yes" to any of these questions, you are required to provide full details on the reverse side of this sheet, or attach an additional 8 ½" x 11" sheet(s) if necessary.**

1.	Have you ever been dropped, suspended, placed on probation, required remediation, expelled, or requested to resign from any school, college, or university?	Yes ☐ No ☐
2.	Have you ever been subject to an investigation of any kind by any licensing Board, jurisdiction, or Agency?	Yes ☐ No ☐
3.	Have you ever been licensed in this state and/or any other state or nation as a physical therapist, nurse, physician's assistant, or in any related capacity?	Yes ☐ No ☐
4.	Have any of the licenses mentioned above or your license to practice Osteopathic Medicine ever been suspended, revoked, or restricted in any way in any licensing jurisdiction?	Yes ☐ No ☐
5.	Have you ever been denied Osteopathic Licensure in any licensing jurisdiction or been granted a license under restrictions of any kind?	Yes ☐ No ☐
6.	Have you ever discontinued practice for any reason for a period of one month or longer?	Yes ☐ No ☐
7.	Have any proceedings ever been filed or instituted against you – either malpractice, criminal, civil, or professional Board related?	Yes ☐ No ☐
8.	Have you ever been convicted of a violation of or pled No Contest to any Federal, State or local statute, regulation or ordinance, or entered into any plea bargain related to a felony or misdemeanor?	Yes ☐ No ☐
9.	Have charges, now or ever, been brought against you by any branch of the Armed Services of the United States?	Yes ☐ No ☐
10.	Have you ever been adjudged incompetent?	Yes ☐ No ☐
11.	Have you ever received any form of psychotherapy or any other treatment for any mental disorder, disability or illness of any kind?	Yes ☐ No ☐
12.	If the answer to #11 is Yes, have you been released from such care in the present time? When were you released? _____ (Example mm/dd/yyyy)	Yes ☐ No ☐
13.	Do you have any chronic medical illness or medical condition which would affect your ability to practice your profession?	Yes ☐ No ☐
14.	Have you ever been admitted to or confined within a hospital or institution for the purpose of obtaining treatment or therapy for any mental or nervous disorder, disability or illness of any kind?	Yes ☐ No ☐
15.	Have you ever had staff privileges denied, restricted or suspended, or have you ever voluntarily resigned in lieu of disciplinary action or while under investigation?	Yes ☐ No ☐

(continued on next page)

Applicant Name _____ **Date** _____

16.	Are you now or have you ever been enrolled in or participated in any drug, alcohol, or impaired practitioners program? Currently, the Board has only designated West Virginia Professionals Health Program, Inc. for this service. If you have received any evaluation or treatment through a different service or provider, you must answer "Yes" and provide a report of your treatment and progress with your application.	Yes ☐ No ☐
17.	Have you ever been denied or relinquished privileges in any third party reimbursement program whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	Yes ☐ No ☐
18.	Are you a member of a state association?	Yes ☐ No ☐
19.	Are you a member of AOA? AOA#:_____	Yes ☐ No ☐
20.	Primary Specialty_____ Are you currently Board certified?	Yes ☐ No ☐
21.	Secondary Specialty_____ Are you currently Board certified?	Yes ☐ No ☐
22.	Are you Active Duty Military?	Yes ☐ No ☐
23.	If you plan on practicing in West Virginia, where do you plan to practice? _____ **Pursuant to West Virginia Code §48A-5A-5(c) each licensee must answer the following questions and certify, under penalty of false swearing, that these answers are true and correct.**	Yes ☐ No ☐
24.	Do you have a child support obligation?	Yes ☐ No ☐
25.	If the answer to question 1, above, is yes, are you in arrearage?	Yes ☐ No ☐
26.	If the answer to question 2, above, is yes, does your arrearage equal or exceed the amount of child support payable for six months?	Yes ☐ No ☐
27.	Are you the subject of a child support related subpoena or warrant?	Yes ☐ No ☐

_____ _____ _____

Applicant's Signature **Applicant's Printed Last Name** **Date of Signature**

LICENSE VERIFICATION FORM

Send a copy to the **Licensing Board** in every state in which you **are or ever have been** licensed – active and inactive. (also include Educational or Training Licenses.)

Note: **Licensing Boards in some states charge a fee for this. Contact their office before mailing this form to them.**

I have applied for a license to practice Osteopathic Medicine and Surgery in the state of West Virginia. Before my request for a license can be reviewed, a background investigation must be completed. I hereby authorize you to release the following information to the West Virginia Board of Osteopathy.

_____ _____
Name in Full (Please Print) (Signature of Applicant)

_____ _____
License # Issue Date

_____
Current Address

_____ _____
Birthdate Soc. Sec. # Other Names Used for Licensure

This section to be completed by State Licensing Board where you are or were licensed:

State of:_____

Full Name of Licensee:_____

Graduate of:_____

License #:_____Issue Date:_____ Expiration Date:_____

Current Status:_____

License Method: ( ) State Board Exam ( ) National Board
( ) Endorsement/Reciprocity ( ) FLEX
( ) Other:_____

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, surrendered or in any other manner limited by a licensing or disciplinary authority in your state? **YES___ NO___**
If yes, please explain,_____

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state that is likely to result in formal disciplinary action? **YES___ NO___**
Cannot answer under state law ___

If yes, please explain _____

Comments:_____

Signed:_____

(Board Seal) Title:_____

Date:_____

LICENSING BOARDS: PLEASE RETURN THIS PAGE DIRECTLY TO:
******* WEST VIRGINIA BOARD OF OSTEOPATHIC MEDICINE *******
405 Capitol Street – Suite 402
Charleston, WV 25301

MEDICAL EDUCATION
(Page 1 of 2)
(Copy this form for multiple schools)

In applying for a license to practice medicine and surgery, the West Virginia Board of Osteopathy requires this form to be completed by each medical school I attended.

Name: _____

Name if different when diploma awarded: _____

Social Security: _____ DOB: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.
Waiver for release of information: I authorize the Medical School below to provide any and all information pertaining to my medical education at your institution to the WV Board of Osteopathy.

_____ _____
Applicant's Signature Date

Certificate of Dean, Secretary, or Registrar of Medical College
(Must be completed by a representative of the Medical School)

This is to certify that_____
(Name of Graduate)

has satisfactorily completed_____ years of medical education

at the_____
(Name of Medical College)

located at_____.
(Address of Medical College)

The aforesaid graduate received the degree of_____

from this College on_____.
(month, day, year)

_____
(Signature)

SEAL OF COLLEGE _____
(Title)

Return this form to:
West Virginia Board of Osteopathic Medicine
405 Capitol Street – Suite 402
Charleston, WV 25301

Medical School Verification – Page 2 of 2
(Copy this form for multiple schools)

APPLICANT'S NAME:_____

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do the records reflect (an) interruption(s) or extension(s) in his/her medical education? **YES** ☐ **NO** ☐

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extensions(s) and check whether the interruption/extension s approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family				
Academic remediation				
Health				
Financial				
Participation in joint degree program (e.g. MD/PhD)				
Participation in non-research special study (e.g., Fellowship, International experience)				
Participation in non-degree research				
Other (Please specify):_____				

2. Do the records reflect that this individual was ever placed on academic or disciplinary probation during his/her medical education? **YES**☐ **NO**☐

If YES, please select the reason(s) for the probation; indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavior		
Probation for other reason		
Please specify reason:_____		

3. Do the records reflect that this individual was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? **YES**☐ **NO**☐

If YES, please provide detailed documentation/information about the circumstances and Outcome(s).____

_____

4. Do the records reflect that this individual was ever the subject of negative reports or an investigation by the medical school or parent university? **YES**☐ **NO**☐

If YES, please provide detailed documentation/information about the circumstances and outcome(s) .____

_____.____

5. Do the records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **YES**☐ **NO**☐

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.____

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Postgraduate Training Verification Form (Form #3)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form to the current program director of your postgraduate training program. Copy this form for multiple programs.

Program Director or Designated Official: Complete Section 2 of this form. Report internship, residency, and fellowship years on separate pages. Make copies of this form and attach additional pages as needed. Mail completed pages and any other documentation if needed to the board at the address listed in Section 1.

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

Name if different when diploma awarded _____

Name of postgraduate training program _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined above. I authorize the postgraduate training program listed above to provide any and all information pertaining to my training there to the board listed below:

Board name WV Board of Osteopathic Medicine

Mailing address 405 Capitol Street, Suite 402

City/State/Zip Charleston, WV 25301

Applicant signature _____ Date _____

Section 2: Postgraduate Training Verification

Institution name _____ Affiliated school _____

Institution address w/country _____

Program year(s) _____ Attendance (mm/yyyy) from _____ to _____ Specialty _____

Program type ☐ Internship ☐ Residency ☐ Internship/Residency ☐ Transitional ☐ Fellowship ☐ Fellowship/Research ☐ Other _____

Training status ☐ Completed ☐ In Training ☐ Not Started ☐ Leave of Absence ☐ Withdrawn ☐ Dismissed

Accredited by ☐ ACGME ☐ AOA ☐ APPAP ☐ CFPC ☐ LCGME ☐ RCPSC ☐ RSC ☐ None

The following questions apply to unusual circumstances that occurred during any part of the individual's training. Check the appropriate responses and explain any "Yes" response on a separate sheet of paper. Attach pages as needed.

1. Did this individual ever take a leave of absence or break from training? Yes ☐ No ☐
2. Was this individual ever placed on probation? Yes ☐ No ☐
3. Was this individual ever disciplined or placed under investigation? Yes ☐ No ☐
4. Were any negative reports for behavioral reasons ever filed by instructors? Yes ☐ No ☐
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes ☐ No ☐

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature _____

Print name _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Title _____ Date _____

Phone number _____ Fax number _____

Email _____

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Send this form to the board you are applying to for licensure. For state medical and osteopathic boards, refer to http://www.fsmb.org/policy/contacts for contact information. Include all other required materials.

To: Board name WV Board of Osteopathic Medicine
Mailing address 405 Capitol Street, Suite 402
City/State/Zip Charleston, WV 25301

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 Uniform Application for Physician State Licensure 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.

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 Photograph

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-type color photo of yourself in this square.

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

_____
Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

_____
Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

State of _____, County of _____,

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.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20____.

Notary Public Signature _____ My Notary Commission Expires _____