

West Virginia Board of Osteopathic Medicine
 405 Capitol Street, Suite 402
 Charleston, WV 25301

Osteopathic Physician Assistant Practice Notification
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Name of Physician Assistant	NCCPA Certification #	License, Registration, or Permit #
Business Address		
City	State	Zip Code
Phone (enter 10 digit #)	Email Address	County
Home Address		
City	State	Zip Code
Home Phone (enter 10 digit #)		County
Health Care Facility Representative		
Name	Job Title	Phone
Office Address		
Email Address		
City	State	Zip Code
Health Care Facility or Facilities		
Name of Facility #1		
Address #1		
Name of Facility #2		
Address #2		
Name of Facility #3		
Address #3		

**Osteopathic Physician Assistant Practice Notification
FORM A**

The Physician Assistant and the Health Care Facility Representative must indicate whether the Physician Assistant’s license is subject to probation or any practice restriction and/or limitation. If the answer is “no,” no further information is required; proceed to the next page. If the answer is “yes,” the Physician Assistant and the Health Care Facility Representative must also complete **FORM A (listed below)**.

1. Restrictions and/or limitations include the following:

2. The Health Care Facility is aware of the Physician Assistant’s practice restrictions and/or limitations; and
3. The Physician Assistant and the Health Care Facility certify that the Physician Assistant’s practice shall comport with all practice restrictions and/or limitations.

Physician Assistant

Health Care Facility Representative

Printed Name

Printed Name

Signature

Signature

Date

Date

CERTIFICATIONS

The Physician Assistant and the Health Care Facility hereby certify that:

1. The Physician Assistant shall practice in collaboration with physicians.
2. The Physician Assistant shall practice in conformity with the Physician Assistant's education, training, and experience and in accord with the delineation of privileges granted to the Physician Assistant by the Health Care Facility or other credentialing requirements of the Health Care Facility.
3. The Physician Assistant holds a license, interstate telehealth registration, or emergency temporary permit issued by the West Virginia Board of Osteopathic Medicine.
4. The Physician Assistant meets the requirements for prescriptive authority and shall exercise prescriptive authority in conformity with the Board's legislative rule, 24CSR2.
5. The Physician Assistant certifies completion of a Board-approved 3-hour CME on drug diversion training and best practice prescribing of controlled substances training within the previous two years prior to submission of this Practice Notification.
6. The Physician Assistant will not commence practice pursuant to the Practice Notification until the Physician Assistant receives written notification from the West Virginia Board of Osteopathic Medicine that this Practice Notification has been activated.
7. The Physician Assistant shall notify the West Virginia Board of Osteopathic Medicine within **10 days** of the termination of the Physician Assistant's practice pursuant to this Practice Notification.

Signature of Physician Assistant

Date

Signature of Health Care Facility Representative

Date

Signature of Board Member

Date

Additional Practice Location(s)

If additional practice locations need to be listed, please complete and submit this form as needed.

Name of Facility #4
Address #4
Name of Facility #5
Address #5
Name of Facility #6
Address #6
Name of Facility #7
Address #7
Name of Facility #8
Address #8
Name of Facility #9
Address #9
Name of Facility #10
Address #10
Name of Facility #11
Address #11