VERIFICATION FORM

SEND A COPY OF THIS FORM TO THE LICENSING BOARD IN ALL STATES IN WHICH YOU ARE OR EVER HAVE BEEN LICENSED

Note: Some states charge a fee for this – contact their office before mailing form to them

I have applied for a license to practice as a Physician Assistant to an Osteopathic Physician 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.

PHYSICIAN ASSISTANT COMPLETE THE TOP PORTION ONLY:

_____ _____

Full Name (Please Print) *Signature of Applicant*

_____

Current Street Address *License # / Certificate # Issue Date*

_____

Current City, State, & ZIP

_____

Birth Date *Social Security Number* *Other Names Used for Licensure*

TO BE COMPLETED BY STATE BOARDS:

Please complete the following questionnaire as it relates to my license in your state.

State of: _____

Full Name of Licensee: _____

Graduate of: _____

License #: _____ Issue Date: _____ Expiration Date: _____

Current Status: _____

License Method: ( ) NCCPA Certification ( ) Other

Has licensed been revoked, suspended, or surrendered? ( ) Yes ( ) No

Reason: _____

Derogatory Information: _____

Remarks: _____

Signed: _____

(Board Seal) Title: _____

Date: _____

Please return it directly to:

WEST VIRGINIA BOARD OF OSTEOPATHIC MEDICINE
405 Capitol Street – Suite 402
Charleston, WV 25301