

The application must be completed in its entirety and submitted with all required documentation and fees. Incomplete submissions will be rejected.

REQUIRED ATTACHMENTS

The following must be included with each application:

- Check or money order made payable to West Virginia Department of Health and Human Resources (WVDHHR) for a non-refundable license fee. Applicable fees are as follows:
 - a. Initial license fee - \$250.00
 - b. Renewal fee
 - i. Fewer than 500 patients \$251.83
 - ii. 500 – 1000 patients \$503.65
 - iii. Over 1000 patients \$755.48
 - c. The clinic shall also pay a \$400 initial inspection fee plus the actual cost of the initial survey inspection. The cost will be billed to the clinic after the inspection and must be paid in full prior to a license being issued.
- Verification of education and training for all physicians practicing at the clinic such as fellowships, additional education, accreditations and board certifications
- Board of Pharmacy Controlled Substance Prescriber Reports for each physician practicing at the clinic for the three months preceding the date of application
- Completed Patient Calculation Sheet for the six months preceding the date of application
- A list of all patients being treated by the clinic for all diagnoses, for the three months preceding the date of application, separated by month
- A list of all patients being treated by the clinic for chronic pain lasting greater than three months, for the three months preceding the date of application, separated by month.
- If applicable, a copy of a valid Certificate of Need or a letter of exemption from the West Virginia Health Care Authority must be included

GENERAL INSTRUCTIONS

Clinic Information

Operating Name – the full operating name of the clinic, as advertised

Legal Name – the legal name of the clinic, as registered with the West Virginia Secretary of State

Physical Address – the physical location of the clinic

Mailing address – the preferred mailing address for the clinic

Email Address – the address to be used as the primary contact for the clinic

Business Information

FEIN Number – Federal Employer Identification Number assigned to clinic

Licenses – list all business licenses issued to the clinic by this state, the state tax department, Secretary of State and all other applicable business entities

Description of Services – brief description of all services provided by the clinic

Total Clinic Census of All Patient Types – total number of all patients treated by the clinic for all diagnoses (*See Required Attachments*)

Total Chronic Pain Patient Census – total number of all patients receiving medications for chronic pain per Legislative Rule 69CSR8 (*See Required Attachments*)

Hours of Operation – days and times the clinic is open for services

Owner Information

Legal Registered Owner Name – name of the person registered as the legal owner of the clinic. If more than one legal owner (i.e. partnership), use the application appendix and list each legal owner separate, indicating percentage of ownership.

Designated Physician Owner

Full Name – full name of person working in the capacity of the Designated Physician Owner of the clinic

Medical License Number – current West Virginia Medical License number

DEA Number – Current DEA Registration Number

Pain Management Certifications – All current pain management certifications held. (*See Required Attachments*)

Management/Personnel (*Complete for each employee of the clinic*)

Owner/Physician/Other – indicate the employee's role within the clinic

Full Name – complete legal name of employee

Medical License – Current West Virginia Medical License number, if applicable

DEA Number – Current DEA Registration Number, if applicable

Occupation – specify employee's position at the clinic

Number of hours worked at clinic – Verifiable number of hours worked per week at this location

If additional space is needed, use the application appendix.

Other Clinic Owned or Operated by Applicant

List any other clinic owned or operated by the applicant, including location address. **All locations must be licensed individually.**

Disclaimer and Signature

The application must be signed by the applicant in the presence of a Notary Public of the State of West Virginia



COMPLETE THIS APPLICATION AND RETURN TO:

Office of Health Facility Licensure & Certification
Attention: Chronic Pain Management Clinic Program
408 Leon Sullivan Way
Charleston, WV 25301-1713
(304) 558-0050

LOG NUMBER _____
DATE _____

OFFICIAL USE ONLY

NOTE: This application can only be accepted if all required fields are completed and additional requested documentation is attached.

CLINIC INFORMATION

Operating Name: _____

Legal Name: _____

Physical Address: _____

Street Address

City

State

ZIP Code

Mailing Address: _____

Street Address

City

State

ZIP Code

Phone: () _____ **Fax:** () _____

E-mail Address: _____

Website URL: _____

BUSINESS INFORMATION

FEIN: _____

Licenses: _____

Description of Services: _____

Total clinic census of all patient types: _____ **Total chronic pain patient census:** _____

***Patient Calculation Sheet must be included**

	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
Hours of Operation:							



OWNER INFORMATION

Legal Registered
Owner Name: _____

Mailing Address: _____
Street Address

City State ZIP Code

Phone: () _____ Fax: () _____

E-mail Address: _____

Percentage of Ownership: _____ Verifiable hours worked at clinic per week: _____

DESIGNATED PHYSICIAN OWNER

Full Name: _____
Last First M.I.

Medical License #: _____ DEA #: _____

Pain Management Certifications: _____

Percentage of Ownership: _____ Verifiable hours worked at clinic per week: _____

** Verification of education and training must be included.*

MANAGEMENT / PERSONNEL

Owner Physician Other

Full Name: _____
Last First M.I.

Occupation: _____ Verifiable hours worked at clinic per week: _____

Medical License # (if applicable): _____ DEA # (if applicable): _____

MANAGEMENT / PERSONNEL

Owner Physician Other

Full Name: _____
Last First M.I.

Occupation: _____ Verifiable hours worked at clinic per week: _____

Medical License # (if applicable): _____ DEA # (if applicable): _____



OTHER CLINIC OWNED OR OPERATED BY APPLICANT

Operating Name: _____

Address: _____

Street Address

City

State

ZIP Code

OTHER CLINIC OWNED OR OPERATED BY APPLICANT

Operating Name: _____

Address: _____

Street Address

City

State

ZIP Code

DISCLAIMER

By signing this application I hereby verify that no owner or operator applying for this license has been the owner or operator of a licensed chronic pain management clinic that has had its license suspended or revoked in the five (5) years preceding the date of this application. I further verify that a criminal records background check has been completed for each anticipated owner, physician, employee, volunteer, associate, or contracted agent.

SIGNATURE

STATE OF WEST VIRGINIA

County of _____

_____, being by me duly sworn on his/her oath, deposes and says that he/she has read the foregoing application and knows the contents thereof: that the statements concerning the above named Center/Agency, therein contained, are correct and true of his/her own knowledge.

Signature of Applicant: _____

Subscribed and sworn to before me this _____ day of _____, 20____.

Notary Public

My Commission Expires: _____