

**STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL
OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION
408 Leon Sullivan Way, Charleston, West Virginia 25301**

<p>INITIAL/RENEWAL APPLICATION FOR LICENSE TO OPERATE A CHRONIC PAIN MANAGEMENT CLINIC INSTRUCTIONS</p>
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Please read carefully and complete this application in accordance with the instructions below. Failure to complete the application in full may result in delay of license being issued.

1. The application must be completed in full; the applicant may type or print legibly using permanent ink.
2. The application must be completed by a person, partnership, association, corporation, or facility operating the chronic pain management clinic. The applicant must sign page 3. The signature must be verified / acknowledged by a Notary Public.
3. The application must be accompanied by a check or money order payable to the West Virginia Department of Health and Human Resources in the amount of:
 - a. **Initial licensure** fee of **\$250.00**;
 - b. **Initial inspection** fee of **\$400.00 plus the costs of the initial inspection**, prior to issuing a license. The cost will be billed to the chronic pain management clinic or owner(s) after the inspections and must be paid in full before a license is issued.
 - c. **Renewal licensure fees are as follows:**
 - i. Programs with an average daily total census of **fewer than five hundred patients** shall remit a fee of **\$250.00 for each annual renewal**;
 - ii. Programs with an average daily total census of **five hundred to one thousand patients** shall remit a fee of **\$500.00 for each annual renewal**;
 - iii. Programs with an average daily total census of **more than one thousand patients** shall remit a fee of **\$750.00 for each annual renewal**.
4. If applicable, it is required that a copy of a valid Certificate of Need or a letter of exemption from the West Virginia Health Care Authority is submitted with the application.

MANAGEMENT AND PERSONNEL OF CHRONIC PAIN MANAGEMENT CLINIC

Describe the organizational structure of the chronic pain management clinic, including the owners, designated physician owner, and administrator:

Complete the data below for each owner, designated physician owner, administrator, and physician:

Name	Address	Principal Occupation	Official Position	Medical Licenses	DEA Number	Pain Management Certifications

List the name and address, including county, of all other chronic pain management clinics owned and operated by this applicant.

Name	Address

APPLICANT

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.

_____, 20 _____

Signature of Individual/Administrative Officer:

Title or Position:

If other than Individual or Administrative Officer:

Name	Address

VERIFICATION

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 chronic pain management clinic, therein contained, are correct and true of his/her own knowledge.

(Signature of Individual/Administrative Officer)

Subscribed and sworn to before me this

_____ Day of _____, 20 _____

Notary Public

My Commission expires: _____