



COMPLETE THIS FORM AND RETURN TO:

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

LOG NUMBER \_\_\_\_\_

DATE \_\_\_\_\_

**OFFICIAL USE ONLY**

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

**CLINIC INFORMATION**

Clinic Name: \_\_\_\_\_

Physician Owner: \_\_\_\_\_  
Last First M.I.

Clinic Address: \_\_\_\_\_  
Street Address

City State ZIP Code

Clinic Phone: ( ) \_\_\_\_\_ Clinic Fax: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**PATIENT CALCULATIONS**

A	B	C	D	E
Month /Year	Total Number of Individual Patient Encounters	Total Number of Chronic Pain Patients	Column C divided by Column B	%

**Example:** Total number of individual patients seen by clinic (count each patient only once per month) = 350  
Total number of patients on pain medications (per WV Code of State Rules §69-8-3.1.b) = 210  
Divide 210 by 350 = 0.6  
0.6 x 100% = 60%

**Calculations shall be for the most recent six months. You must include supporting documentation used when making your calculations; such as patient rosters, Board of Pharmacy reports or similar information.**

**SIGNATURE**

I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information on this document may result in denial of license.

Signature of Physician Owner: \_\_\_\_\_ Date: \_\_\_\_\_