# Limited Physician and Surgeons Application Packet

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## Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, please complete the Social Security Number Notification.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

## In order to process your request:

**Mail only your application with your check or money order payable to:**

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

**Send additional documents to:**

Washington Medical Commission
P.O. Box 47866
Olympia, WA 98504-7866

## Contact us:

360-236-2750

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

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# Application Instructions Checklist

**Important background check Information:** Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly. It is your responsibility to submit the correct forms required.

☐ **Application Fee**. (This fee is non-refundable). You can check the **fee page** for current fees.

☐ **Select if the following applies:**
Spouse or Registered Domestic Partner of Military Personnel

☐ **1. Demographic Information:**
**Social Security Number:** You must list your social security number on your application. Please complete the Social Security Number Notification if you do not have one.

**National Provider Identifier Number (NPI):** The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

**Legal Name:** List your full name.

**Definition of legal name:** "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

**Birth date:** Provide the month, day, and year of your birth.

**Address:** List the address we should use to send any information on your credential. Be sure to include the city, state, zip code, county and country. This will be your permanent address with Department of Health until we have been notified of a change. See **WAC 246-12-310**.

**Phone, Fax, and Cell Numbers:** Enter your phone, fax, and cell numbers, if applicable.

**Email:** Enter your email address, if applicable.

**Other Name(s):** Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **Institution or Training Program Information:**
List the name of the institution or training program and the address.
**Required** you must provide this information to become licensed.

- Physicians with a limited license may **not** change their institution address. Only the program may submit evidence of a program address change.

☐ **Medical Specialty:**
List medical school, year of graduation, and medical specialty.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 3 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- "Another jurisdiction" means any other country, state, federal territory, or military authority.

☐ **3. Medical Education and Postgraduate Training:**
List in chronological order your medical school education. Verify all postgraduate training received in the United States or Canada. Verification must be completed by the program director with beginning and ending dates and sent directly to the Medical Commission.

☐ **4. Professional Experience:**
List in chronological order any professional experiences you have had since medical school. A Curriculum Vitae or resume will **not** be accepted in lieu of completing this section of the application. If you need more space, attach a piece of paper.

☐ **5. Hospital Privileges Verification:**
Excluding postgraduate training hospital privileges:
Do not list any postgraduate training hospital privileges. If you had independent hospital privileges outside of a training program, please request all hospital privileges granted in the past five years verified and sent directly to this department. Forms provided.

☐ **6. Licenses in Other States:**
List in chronological order all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. Please provide verification directly from the state(s) that you have listed in this section.

☐ **7. Applicant's Photograph:**
Attach a current photograph, taken within the last year, in the box provided or attach to the application. Indicate the date the photograph was taken. Sign in ink across the bottom of the photo. The photograph must be a clear, close up, with a front view of applicant.

☐ **8. Applicant's Attestation:**
You must sign and date this for us to process the application.

## For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

## Limited Licenses Categories with specific requirements

**Resident Physician Limited License:**

- ☐ Includes interns and medical residents and fellows.
- ☐ The program must submit a residency certification form stating the beginning date of the program. The document must be original and submitted directly to this office by the program.

**Fellowship or Teaching/Research Limited License**

- ☐ A letter of nomination from the dean of the medical school at the University of Washington or chief executive of hospital or other appropriate health care facility licensed in the state of Washington. The letter must state the program start date.
- ☐ License verification from state or country of origin—state license verification must be original and received direct from licensing entity; licenses from country of origin may be a notarized copy of original license documents. A fellowship license has a limit of two years total.

**Institutions or County-City Health Department Limited License:**

- ☐ Original letter verifying employment received directly from official department. The letter must state employment start date.
- ☐ License verification from state or country of origin—state license verification must be original and received direct from licensing entity. Licenses from country of origin may be a notarized copy of original license documents.

Note: A limited license is only for practicing medicine within the limitation of the specific training program or institution or county-city department.

**All application documentation required:**

**Malpractice:** (if applicable) All medical malpractice law suits you have been named in must be reported and should include the nature of the case, date and summary of care given on the professional liability form provided. The applicant must also include copies of the settlement or final disposition. If pending, indicate status.

**Transcripts:** All medical school transcripts must list the dates of attendance, subject completed, degree and date awarded and sent directly to this office.

- **Exception:** A letter of verification from the dean of medical school will be accepted for a limited license; however, a copy of the official transcripts must be submitted. (Form provided)
- **Foreign Transcripts:** Foreign medical school transcripts must list the dates of attendance, subjects completed; degree and date awarded and be sent directly to this office. All documentation must be translated to English. All translations must be original documents with the appropriate signatures and seals.

**FSMB Data Bank Clearance and the AMA Physician Profile (Only those who have completed prior training in the U.S.):** The Federation of State Medical Boards data bank clearance and the American Medical Physician Program will be obtained electronically by Department staff. If staff is unable to obtain either report, the applicant is responsible to obtain the reports and pay the necessary fees.

Washington State Department of Health

# Social Security Number Notification

I have not provided a social security number for the following reason:

- ☐ I do not have a social security number, and when I applied for one, it was denied. (Attach any correspondence received from the Social Security Administration.)
- ☐ I do not have a social security number, but I have an individual taxpayer identification number, which is _____.
- ☐ I am a foreign national with a student visa only and do not qualify for a social security number because of that visa status.
- ☐ I will be in the United States on a visa and cannot apply for a social security number until my visa has been approved and I have entered the United States.
- ☐ I do not have a social security number, and when I applied for one, it was denied.
- ☐ Other (Provide a detailed explanation)

_____

_____

_____

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

_____ Printed Name

_____ Signature

_____ Place Signed

_____ Date Signed

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Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue 0252140000

# Limited Physician & Surgeons License Application

☐ Resident Physician ☐ Teaching/Research ☐ Institutional
☐ Fellowship (2 year limit) ☐ County/City Health Department

**Select if the following applies:** ☐ Spouse or Registered Domestic Partner of Military Personnel

## 1. Demographic Information

| **Social Security Number (SSN)** (If you do not have a SSN, see instructions) | **National Provider Identifier Number (NPI)** (Enter 10 digit number) | ☐ Male ☐ Female |
|---|---|---|

Name First Middle Last

Birth date (mm/dd/yyyy)

Address

| City | State | Zip Code | County |
|---|---|---|---|

| Phone (enter 10 digit #) | Fax (enter 10 digit #) | Cell (enter 10 digit #) |
|---|---|---|

Email Address:

Have you ever been known under any other name(s)? If yes, list name(s):

Will documents be received in another name? If yes, list name(s):

## Institution or Training Program Information (Required)

Please provide the institution or training program in WA that you will be participating in.

Institution/Program Name

Institution/Program Mailing Address

| City | State | Zip Code | County |
|---|---|---|---|

**Medical Speciality**

Medical school

Medical Specialty

## 2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way currently impairs or limits your ability to practice your profession with reasonable skill and safety?..... ☐ ☐

   **If yes, please attach any supporting documentation and a detailed explanation**

   **"Medical Condition"** includes physiological, medical, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, sleep disorder, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   **You may answer No if the behavior or condition is already known to the Washington Physician Health Program (WPHP). "Known to WPHP" means that you have informed WPHP of your behavior or conditions and you are complying with all of WPHP's requirements for evaluation, treatment, and/or monitoring.**

   **If Yes, You must submit detailed information to the Commission that will allow the Commission to assess your ability to practice safely, competently, and without impairment to your professional judgment, skill, or knowledge. In addition to this information, you are required to provide copies of any related records, reports, evaluations, police reports, probation reports, and court records directly to the Commission.**

**Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

**The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain..... ☐ ☐

   **"Currently" means within the past six months.**

   **"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.**

**Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

3. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? .....☐ ☐

**Note: If you answered "yes" to question 3, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

**To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

## 2. Personal Data Questions (Cont.)

| | Yes | No |
|---|---|---|
| 4. Have you ever been found in any civil, administrative or criminal proceeding to have: | | |
| a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? | ☐ | ☐ |
| b. Diverted controlled substances or legend drugs? | ☐ | ☐ |
| c. Violated any drug law? | ☐ | ☐ |
| d. Prescribed controlled substances for yourself? | ☐ | ☐ |
| 5. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? | ☐ | ☐ |
| 6. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? | ☐ | ☐ |
| 7. Have you ever surrendered a credential like those listed in number 6, in connection with or to avoid action by a state, federal, or foreign authority? | ☐ | ☐ |
| 8. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? | ☐ | ☐ |
| 9. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied? | ☐ | ☐ |
| 10. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?. | ☐ | ☐ |
| 11. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?. | ☐ | ☐ |
| 12. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?. | ☐ | ☐ |
| 13. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? | ☐ | ☐ |

## 3. Education

List all Medical School Education

| Schools attended (Location if other than U.S., quote names of schools in original language and translate to English.) | Diploma or degree obtained (Quote titles in original language and translate to English.) | Number of years attended | Dates granted | |
|---|---|---|---|---|
| | | | Start (mm/yyyy) | End (mm/yyyy) |
| Medical education (list all medical schools attended) | | | | |
| | | | | |
| | | | | |
| Postgraduate training (list all programs attended) | | | | |
| | | | | |
| | | | | |

## 4. Professional Experience

In date order, most recent to later, list all professional experience received since graduation to the present. Exclude activities listed under other sections, identify any periods of time break of 30 days or more.

| Name and location of institution | From (mm/dd/yyyy) | To (mm/dd/yyyy) | Nature of experience or specialty |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## 5. Hospital Privileges Verification

Excluding postgraduate training, list hospitals where all privileges that have been granted within the past five years. If you need more space, attach a piece of paper.

| Name of hospital | Dates attended | |
|---|---|---|
| | Start Date (mm/dd/yyyy) | End Date (mm/dd/yyyy) |
| | | |
| | | |
| | | |
| | | |
| | | |

## 6. Licenses in Other States

List all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. Please provide verification directly from the state(s) that you have listed in this section.

| State | Date license issued | License Number | Status of license | Any limitations on license |
|---|---|---|---|---|
| | | | | ☐ No ☐ Yes |
| | | | | ☐ No ☐ Yes |
| | | | | ☐ No ☐ Yes |
| | | | | ☐ No ☐ Yes |
| | | | | ☐ No ☐ Yes |
| | | | | ☐ No ☐ Yes |

## 7. Applicant's Photograph

**Photo Here**

Attach current photograph here. Indicate date taken and sign in ink across bottom of the photo.

NOTE: Photograph **must** be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view of applicant

Height _____

Weight _____

Hair color _____

Color of eyes _____

Signature _____

Date of Photo _____

## 8. Applicant's Attestation

I, _____ , declare under penalty of perjury under the
(Print applicant name clearly)

laws of the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(city, state)

By: _____
Signature of applicant

Washington State Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360-236-2750

**LMT**

# Malpractice / Liability History

Applicant's name: _____ Today's date: _____

Please submit a form for each past or current professional liability claim or lawsuit which has been filed against you. Photocopy this page as needed. Only a legible and signed narrative which addresses all of the following details will be accepted.

1. Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. Please submit additional pages of narrative if necessary.

   _____

   _____

   _____

   _____

   Date of occurrence: _____ Details: _____

   _____

   _____

   _____

2. Date suit or claim was filed: _____

   Name and address of insurance carrier that handled the claim: _____

   _____

3. Your status in the legal action (primary defendant, codefendant, other):
4. Current status of suit or other action:
5. Date of settlement, judgment, or dismissal:
6. If the case was settled out of court, or with a judgment, settlement amount paid on your behalf, please disclose the amount.

**You must enclose a copy of final disposition of case this includes dismissals.** $ _____

I verify the information contained in this form is correct and complete to the best of my knowledge:

Signature _____ Date _____

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Washington State Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360-236-2750

LMT

# Request for Medical School Transcripts

University Medical School

Address

I am applying for license to practice medicine in the state of Washington. Please send a copy of my medical school transcripts (with the MD degree and date granted posted) directly to the Washington State Medical Quality Assurance Commission at the address below. Thank you for your assistance.

Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866

I authorize release of my medical school transcripts to be sent to Department of Health

Signature Date

**Note: If a transcript is not yet available, submit a letter of degree confirmation.**

**Applicant:** Please complete the identifying information below to assist the registrar's office in processing your request.

Student name_____

Social Security Number _____

Year of graduation _____ Birth date_____

(This page intentionally left blank.)

Washington State Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360-236-2750

LMT

# Postgraduate Training Program Director Verification and Evaluation of Training

**To be completed by the applicant:**

Facility name _____

Address _____

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the postgraduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown below. **All questions must be answered.**

| Applicant Name (Print or type) | Birth date (mm/dd/yyyy) |
|---|---|
| Signature of applicant | |

**To be completed by the facility/agency/program:**

1. _____ is or was engaged in postgraduate training in our
   Applicant Name (Print or type)
   program _____

   from Beginning date (month/year) _____ to Ending date (month/year) _____

   in the field of _____
2. At the time this individual was in training, was this program accredited through the accreditation council for graduate medical education, the Royal College of Physicians and Surgeons, or the college of family Physicians of Canada? ☐ Yes ☐ No
   If no, does this program qualify the applicant to become board certified? ☐ Yes ☐ No
3. Was the participant ever placed on probation, restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? ☐ Yes ☐ No

   If yes, please explain _____
4. Did this applicant successfully complete this training program? ☐ Yes ☐ No
   ☐ in process OR ☐ expected date of completion _____

(SEAL)

Signature _____

Title _____

Email _____

Address _____

_____

**Return to address listed above**

Date _____ Phone _____

(This page intentionally left blank.)

Washington State Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360-236-2750

LMT

# Medical Licensing Board Verification

**To be completed by the applicant:**

Name of State Medical Board _____

Address _____

_____

I am applying for a license to practice medicine as a physician and surgeon in the state of Washington and before my application can be reviewed, a verification of my license status in your state is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown above. **All questions must be answered.**

| Applicant Name (Print or type) | Birth date (mm/dd/yyyy) |
|---|---|
| Signature of applicant | |

**To be completed by the facility/agency/program:**

This is to verify that _____ was issued license
Applicant Name (Print or type)

number _____ on _____
(mm/dd/yyyy)

1. Date license, registration, or certification expires _____
2. Have any complaints been lodged against the license? ☐ Yes ☐ No
3. Is there currently any investigation in process regarding the license? ☐ Yes ☐ No
4. Has any disciplinary activity taken place regarding the license? ☐ Yes ☐ No

If yes, please provide any information or documentation which may be released; i.e., charges and final disposition.

**Return to address listed above.**

(SEAL)

Signature _____

Title _____

Email _____

State Medical Board _____

Address _____

_____

Date _____ phone _____

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Washington State Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360-236-2750

LMT

# Hospital Privileges Verification

**(Excluding postgraduate training hospital privileges)**

**To be completed by the applicant:**

Hospital Name _____

Address _____

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information **directly** to the address shown above at your earliest convenience. **All questions must be answered.**

| Applicant Name (Print or type) | Birth date (mm/dd/yyyy) |
|---|---|
| Signature of applicant | |

**To be completed by the facility/agency/program:**

1. _____ has/had admitting or specialty privileges at
   Applicant Name (Print or type)

   this hospital from _____ to _____.
   (mm/yyyy) (mm/yyyy)

2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?

   ☐ Yes ☐ No If yes, please explain _____

   _____

3. Has the applicant ever been asked to resign? ☐ Yes ☐ No If yes, please explain _____

   _____

4. Did the applicant ever resign in lieu of or to avoid adverse action? ☐ Yes ☐ No If yes, please explain

   _____

5. Has a report concerning the applicant ever been sent to the National Practitioner Data Bank or the Health Care Integrity and Protection Data Bank by this hospital? ☐ Yes ☐ No

(SEAL)

**Return to address listed above.**

Signature _____

Title _____

Email _____

Address _____

_____

Date _____ phone _____

(This page intentionally left blank.)

Washington State Department of Health

LMT

# Resident Physician Limited License

This certifies the appointment of the following individual who is being recommended for a limited license in Washington State.

Name of Resident Physician* _____

Name of training program/specialty _____

Name of sponsoring institution _____

Beginning date_____
mm/dd/yyyy

Signature _____
Director of Program

Is this an ACGME Program? ..... Yes ☐ No ☐

* Resident physician means an individual who has graduated from a school of medicine which meets the requirements set forth in **RCW 18.71.055** and is serving a period of postgraduate clinical medical training sponsored by a college or university in this state or by a hospital accredited by this state. The term shall include individuals designated as intern or medical fellow.

**Note: The issuance of a limited license does not allow the individual to engage in the practice of medicine outside the supervision of the postgraduate clinical medical training program.**

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# Health Professions Reference Numbers and Links

## RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Physician Laws, RCW 18.71

Physician Rules, WAC 246-919

## Continuing Education

Physician Continuing Education Rules, WAC 246-919-460

## Online

Washington Medical Commission