Washington State Department of Health
Washington Medical Commission
P.O. Box 47866
Olympia, WA 98504-7866
Medical.commission@wmc.wa.gov
360-236-2750

MD

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

   Signature _____

   Title _____

   Email _____

   Address _____

   _____

   Date _____ Phone _____