WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Physician Assistant License Activation Application Packet Expired Less Than Three Years

Contents:

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, contact the Customer Service Center at 360-236-2750 for more information.

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 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:

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

Contact us:

360-236-2750

(This page intentionally left blank.)

Application Instructions Checklist

When your application is received by the department, you will be sent a letter noting receipt and any documents needed to complete the process. This is the only notice you will receive while your application is pending. Please do not call to check on the status of an application until you have received your acknowledgement letter. This will permit program staff to prepare your file and re-activate your license at the earliest possible time.

To ensure that you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- ☐ **Pay Late Penalty Fee.**
- ☐ **Pay Current Renewal Fee.**
- ☐ **Pay Expired Credential Reissuance Fee.**
  All fees are non-refundable. These fees are located on the **fee page**.
- ☐ **1. Demographic Information:**
  Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360-236-2750 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: first, middle, and last.

  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 you were born.

  Birth place: Provide the city, state, and country where you were born.

  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**.

☐ **2. Licenses in Other States:**
List all previous and current licenses, registration and certification of any health care profession you have held starting with the most current. Attach additional pages if you need more space. Please provide verification directly from the state(s) that you have listed in this section.

☐ **3. Professional Experience:**
In date order, list all professional work experience since you completed your physician assistant program. Attach additional pages if you need more space.

☐ **4. AIDS Education and Training Attestation:** Required by **WAC 246-12-040.**

☐ **5. Disciplinary Action Attestation:** Required by **WAC 246-12-040.**

☐ **6. Continuing Education Attestation:** Required by **WAC 246-12-040.**

☐ **7. Applicant's Attestation:** Required to be both signed and dated in order to process the application.

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Background Check Stamp Here

Date Stamp Here

Revenue 0252110000

Physician Assistant License Activation Application Expired Less Than 3 Years

Please print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so could result in a delay in processing your application.

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)	**Place of birth**		
	City	State	Country

Address

City	State	Zip Code	County

Country

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

Email address

Mailing address if different from above address of record

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

2. Licenses in Other States

List in date order, starting with most current, all licenses to practice medicine as a physician assistant 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

3. Professional Experience

Nature of experience of practice and location	start (mm/yyyy)	end (mm/yyyy)

4. AIDS Education and Training Attestation (Check Appropriate Box)

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

APPLICANT'S INITIALS

5. Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

APPLICANT'S INITIALS

6. Continuing Education/Continuing Competency Attestation (If Applicable)

I certify that I have met all continuing education and competency requirements for the past two years. I am enclosing documentation on all classes attended/claimed. Current NCCPA is accepted in lieu of CME.

APPLICANT'S INITIALS

7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of the state of
(Print applicant name clearly)
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 _____ in _____
(city, state)

By: _____
(Signature of applicant)

(This page intentionally left blank.)

RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Physician Assistants, RCW 18.71A

Physician Assistants, WAC 246-918

Physician assistant fees and renewal cycle. Licenses must be renewed every two years on the practitioner's birthday. See WAC 246-918-990

How to obtain an initial credential. The initial credential will expire on the practitioner's birthday. Initial credentials issued within ninety days of the practitioner's birthday do not expire until the practitioner's next birthday. See WAC 246-12-020(3)

Address changes. It is the responsibility of each practitioner to maintain his or her current address on file with the department. Requests for address changes must be made in writing. The mailing address on file with the department will be used for mailing of all official matters to the practitioner. See WAC 246-12-310

Continuing Education

Physician Assistants Continuing Education Rules, WAC 246-918-180

On-Line

Medical Quality Assurance Commission, Web Page