Washington State Department of Health

Physician Assistant License Activation Application Packet Expired Over 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:

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

Contact us:

360-236-2750

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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 online **fee page** for current fees.

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

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**.

☐ **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. Training and Education:**
Please list all educational and postgraduate training programs attended from the start of your physician assistant education program to current. Please include the month and year in the beginning and end dates.

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

☐ **5. Hospital Privileges:** (Not for training privileges)
Applicants must have verification sent directly to this office from all hospitals where admitting or specialty privileges have been granted in the past five years. Verifications must be received directly from each hospital. (Form provided)

- Verification for military hospital privileges may be obtained by the current duty station or, if no longer in active service, National Personnel Records Center, Military Personnel Records, 1 Archives Dr, St Louis MO 63138.

☐ **6. 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.

☐ **7. AIDS Education and Training Attestation:**
AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training, required by **WAC 246-12-260** course content can be found at **WAC 246-12-270**. If AIDS education was included in your professional education or training, an additional course is not required.

☐ **8. 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.

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

Additional Information:

☐ **Reporting Medical Malpractice:**
Reporting of any medical malpractice history must be submitted on the Professional Liability Action History form. Malpractice information must include detailed information on the nature of the case, date and summary of care given. The applicant must also include copies of the settlement paid by you or on your behalf or judgment. If pending, indicate status. (Form provided)

☐ **FSMB Profiles and NCCPA Certification:**
The department staff will obtain Federation of State Medical Boards (FSMB) data bank clearance report and the NCCPA Certification. However, if staff is unable to obtain the reports electronically, the applicant will be required to submit requests and pay any applicable fees.

Prior to applying for license, please consider all the following laws on applications:

- The following conduct, acts or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter.
- Fees submitted with applications for initial credentialing, examinations, renewal, and other fees associated with the licensing and regulation of the profession are non-refundable.
- An application for a license may not be withdrawn after the commission or the reviewing commission member determines that grounds exist for denial of the license or for the issuance of a conditional license.

After the application and fees have been received by the Department of Health, the applicant will be notified if any documents or data are missing. Applicants should allow a minimum of four to eight weeks for processing. Only complete applications will be considered for review. Routine applications require five days for processing. Non-routine applications require more time for processing. All information, documents, data, etc. provided to the department by the applicant will become a part of the file.

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Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue 0252090000

Physician Assistant License Activation Application Packet Expired Over Three 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):

Physician Assistant Program	Year of Graduation
NCCPA Certification Number	Date Issued

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. Training and Education

Provide in date order, a listing of your educational preparation and postgraduate training. Attach additional pages if you need more space.

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
Physician assistant education (list all physician assistant 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 (Excluding postgraduate training hospital privileges.)

Excluding postgraduate training, list hospitals where all privileges that have been granted within the past five years. Attach additional pages if you need more space.

Name of hospital	Dates attended	
	Start date mm/dd/yyyy	End date mm/dd/yyyy

6. 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

7. AIDS Education and Training Attestation

I certify that I have completed a minimum of four hours of education in the prevention, transmission, and treatment of AIDS. This education included 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. If AIDS education was included in your professional education or training, an additional course is not required.

Applicant's initials	Date

8. 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 _____

9. 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 have read all laws and rules related to my profession.

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

PA

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
Washington Medical Commission
PO Box 47866
Olympia, WA 98504-7866
360-236-2750

PA

Licensing Board Verification

To be completed by the applicant:

Name of State Board _____

Address _____

_____

I am applying for a license to practice medicine as a physician assistant 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 _____

State Board _____

Address _____

_____

Date _____ phone _____

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Washington State Department of Health
Washington Medical Commission
PO Box 47866
Olympia, WA 98504-7866
360-236-2750

PA

Hospital Privileges Verification

(Not for training purpose.)

To be completed by the applicant:

Hospital Name _____

Address _____

_____

I am applying for a license to practice as a physician assistant 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)	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)
   this hospital from _____ (mm/yyyy) to _____ (mm/yyyy).

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

   ☐ Yes ☐ No If yes, please explain _____

   _____

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

   _____

Return to address listed above.

(SEAL)

Signature _____

Title _____

Email _____

Address _____

City, State, Zip Code _____

Date _____ Phone (enter 10 digit #) _____

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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

Online

Washington Medical Commission, Web Page