



Limited Physician and Surgeon Clinical Experience License Application Packet

Contents:

- 1. 657-135...Contents List/SSN Information/Mailing information.....1 page
- 2. 657-136...Application Instructions Checklist.....2 pages
- 3. 657-137...License Requirements.....2 pages
- 4. 657-138...Limited Physician and Surgeon Application5 pages
- 6. 657-099...Malpractice / Liability History Form1 page
- 8. RCW/WAC and Online Website Links1 page

Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. [42 U.S.C. § 666\(a\)\(13\)](#); [RCW 26.23.150](#). It will be used under the state’s child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the [Declaration of No Social Security Number Form](#). Please call the Customer Service Center at 360-236-4700 if you have questions.

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

Medical.Licensing@wmc.wa.gov

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 in blue or black ink. 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.

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. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the [Declaration of No Social Security Number Form](#). Please call the Customer Service Center at 360-236-4700 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 when 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 Cell Numbers: Enter your phone 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. Education:

List in chronological order your medical school education.

4. Medical Specialty:

List the Medical Specialty in which you were trained and/or practiced in outside of the United States. This should coincide with the specialty you will be practicing within the scope of practice with your primary supervisor.

5. Applicant’s Attestation:

You must sign and date this for us to process the application. Please read thoroughly to ensure your understanding of the provisions in this section.

License Requirements

Federation Credentials Verification Services (FCVS) Verification: The Commission accepts documents submitted by the FCVS in lieu of original primary source verification for the following: verification of medical education, postgraduate training, examination history, ECFMG, board action history, board certification and identity. For more information, please visit the [FCVS website](#).

Medical School Transcripts:

Official transcripts will only be required if you are not licensed in other state or if your Medical School is not verified on the AMA Physician Profile. If you need to request official transcripts please have them sent directly from the applicant's medical school to this office listing the dates of attendance, subjects completed, degree and date awarded. They can be sent electronically from the Medical School to medical.licensing@wmc.wa.gov.

Letter of Nomination:

We will need a letter of nomination sent directly from Chief Medical Officer of any hospital, appropriate medical practice, the Department of Children, Youth, and Families (DCYF), the Department of Social and Health Services (DSHS), the Department of Corrections (DOC), or a county or city health department. The letter must state employment start date.

Medical License Examination Requirements:

Applicants must pass all steps of the United States Medical License Examination (USMLE).

Official license examination certification must be sent directly from the office of record. USMLE scores must be received directly from the Federation of State Medical Boards. You can obtain the request form through their [website](#).

AMA and FSMB Profiles:

The department staff will obtain the American Medical Association (AMA) Physician profile report and the Federation of State Medical Boards (FSMB) data bank clearance report. However, if staff is unable to obtain the reports electronically, the applicant will be required to submit requests and pay any applicable fees.

ECFMG Certification:

Educational Commission for Foreign Medical Graduates (ECFMG) Certification must be sent directly from the ECFMG to this office stating that the applicant has been issued a standard certificate with an indefinite status. The request for certification can be obtained through the [ECFMG's website](#).

Proof of Residence

In order to qualify for this license, applicants must be a resident in the state of Washington for at least one year. Applicants must submit proof of residence by providing the Commission with one of the following:

- WA State issued ID
- WA Driver's License
- WA Voter's Registration

Practice Agreement

Before the Commission can grant this license, applicants must submit a practice agreement with a supervising physician. This agreement will need to list the job duties the applicant will be performing at the place of employment. For more information and to submit the practice agreement, please visit the [Medical Commission's Website](#).

Applicants must meet all the licensing requirements listed above to be granted a license. The Commission does not allow completed applications to be withdrawn. Applicants that submit a completed application and do not meet the requirements may have their application denied by the Commission.

After the application and fees have been received by the Commission, the applicant will be notified if any documents or data are missing as only complete applications will be considered for review.

- Once the application is completely submitted, routine applications require 14 days for processing. Non-routine applications require more time for processing.
- All information, documents, data, etc. provided to the Commission by the applicant will become a part of the file.
- It is the responsibility of the applicant to provide verification information in support of the application for a physician license. Documents submitted in support of the application must be submitted directly from the originating source.
- Applications that are pending for one year will become invalid, along with the fee and any other supporting documentation. It will be necessary to begin the process over with a new application, current fee, and all supporting documents.

Background
Check
Stamp
Here

Date
Stamp
Here

Revenue 0252090000

Limited Physician and Surgeon Clinical Experience Application

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)	<input type="checkbox"/> Male	<input type="checkbox"/> Female
		<input type="checkbox"/> Prefer Not to Answer	
		<input type="checkbox"/> X	

Name	First	Middle	Last
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Birth date (mm/dd/yyyy)	Email
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Address			
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City	State	Zip Code	County
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Country

Phone (enter 10 digit #)	Cell (enter 10 digit #)
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Employer Name	Employer Email
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Employer Address			
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City	State	Zip Code	County
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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. 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.)	Dates Attended		Date of Graduation mm/dd/yyyy
		Start mm/yyyy	End mm/yyyy	
Medical education (list all medical schools attended)				

4. Medical Specialty

What did you train/practice in outside of the US?

5. 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 _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

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Washington Medical Commission
 P.O. Box 47866
 Olympia, WA 98504-7866
medical.licensing@wmc.wa.gov
 360-236-2750

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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RCW/WAC and Online Website Links

RCW/WAC Links

[Uniform Disciplinary Act, UDA RCW 18.130](#)

[Administrative Procedure Act, APA RCW 34.05](#)

[Administrative procedures and requirements, WAC 246-12](#)

[Physician, RCW 18.71](#)

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](#).

Online

[Washington Medical Commission Web Page](#)