Washington State Department of Health
Washington Medical Commission
PO Box 47866
Olympia, WA 98504-7866
Medical.commission@wmc.wa.gov
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 _____ to _____.
   (mm/yyyy) (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.

Signature _____

Title _____

Email _____

Address _____

City, State, Zip Code _____

Date _____ Phone (enter 10 digit #) _____