WASHINGTON
Medical
Commission
Licensing. Accountability. Leadership.

Washington Medical Commission
P.O. Box 47866
Olympia, WA 98504-7866
360-236-2750

MD

Associate Professor or Higher Verification

To be completed by the applicant:

Institution name		
Address		
City	State	Zip Code

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of my position as an associate professor or higher in your institution 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:

_____ has continuously held a position of associate
Applicant Name (Print or type)
professor or higher at the above named institution.

Beginning date (month/year) _____ to Ending date (month/year) _____

Has this applicant had any disciplinary action in the previous five years? ☐ Yes ☐ No

If yes, please explain: _____

_____

(SEAL)

Signature _____

Title _____

Email _____

Address _____

_____

Date _____ Phone_____

Return directly to the address listed above