Limited Physician and Surgeon Clinical Experience License Application Packet

Contents:

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.

Washington State Department of Health

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)	☐ Male ☐ Female ☐ Prefer Not to Answer ☐ X

Name First Middle Last

Birth date (mm/dd/yyyy)	Email

Address

City	State	Zip Code	County

Country

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

Employer Name	Employer Email

Employer Address

City	State	Zip Code	County

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

Please Note:

The commission does not inquire about personal medical conditions unless notified that they represent a limitation or impairment to safe medical practice.

"Medical Condition" includes social, behavioral, physical, physiological, and psychological conditions or disorders. the Medical Commission does inquire about substance use of applicants. If you have a medical condition or substance use disorder that may limit or impair your ability to practice medicine safely, it is your responsibility to contact the Washington Physician Health Program (WPHP) for an assessment: 800-552-7236. If the behavior or condition is "Known to WPHP", that means you have informed WPHP of your medical condition(s) and you are complying with all WPHP requirements for evaluation, treatment, and/or monitoring - if any. The WMC considers this a safe haven in the application process.

Acknowledgement and Agreement

By submitting this application, you acknowledge and agree to the following:

If the Commission has information that you may be suffering from a condition for which you are not being appropriately treated that impairs your judgement or would adversely affect your ability to practice medicine in a competent, ethical, and professional manner, the Commission may request that you undergo an evaluation with the WPHP or obtain other health examinations at your expense. By submitting this application, you consent to such examination(s). You also agree the full and complete examination report(s) may be provided to the Commission, which is the regulatory authority of the license. You waive all claims based on confidentiality or privileged communication. You understand that failure to submit to a required examination(s) or provide the requested report(s) to the Commission may be grounds for denying your application.

1. Do you currently use any substance that impairs in any way your ability to practice with reasonable skill and safety that is not known to a physician's health program? If yes, please explain..... ☐ ☐

"Currently" means within the past six months.

"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 at the time of application submission. The department does criminal background checks on all applicants.

2. Have you ever as an adult **(Adult is definied as age 18 or older)** ..... ☐ ☐

   a. Been arrested on suspicion of impairment:

   b. Been prosocuted for or convicted of a crime:

   c. Entered a plea of guilty or no contest:

   d. Had a sentence deferred or suspended:

Note: 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. If you answered "yes" to question 2, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents at the time of application submission, your application is incomplete and will not be considered.

2. Personal Data Questions (Cont.)

	Yes	No
3. Have you ever been found in any civil, administrative, or criminal proceeding to have violated any laws relating to drugs or the practice of health care?	☐	☐
4. Have you ever been the subject of any public or private action, disciplinary or not, related to the practice of medicine by a licensing board or other health care entity (hospital, professional society or similar)?	☐	☐
5. Have you ever had any license, certificate, registration, or other privilege to practice a health care profession denied, revoked, surrendered or suspended by any state, federal, or international authority?	☐	☐
6. Do you have any history of malpractice litigation or medical liability lawsuits? If yes, please use the appropriate forms to provide details.?	☐	☐
7. Have you ever had hospital privileges revoked, suspended, restricted or denied for any amount of time?	☐	☐
8. Have you ever been disqualified from working with vulnerable persons by the Washington Department of Social and Health Services (DSHS) or similar out of state agency?	☐	☐
9. To the best of your knowledge as of the date you are submitting this application, are you the subject of any investigation by a health profession licensing board or any other state, federal, or international entity (regulatory, law enforcement or similar)?.	☐	☐

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

MDCE

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