



HSQA Office of Customer Service
PO Box 1099
Olympia, WA 98507-1099
360-236-4700

Retired Active Credential Renewal Declaration of Practice

Name (please print or type)	
License Number	Birth Date (mm/dd/yyyy)
<p>I, _____,</p> <p>certify that I am the person described and identified as listed above and that in the last renewal cycle, I have practiced only intermittently (no more than 90 days) or in an emergency in the state of Washington.</p> <p>Should I furnish false or misleading information on this declaration, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my credential to practice in the state of Washington.</p>	
Applicant's Signature	Date (mm/dd/yyyy)