



Washington State Department of

Health

Dental Quality Assurance Commission
Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

DEA Authorization

To the Applicant: Fill out this form if licensed in another state.

Please complete the identifying information and submit this form directly to:

Drug Enforcement Administration
Attention: Diversion Unit, Registration
300 5th Ave Ste 1300
Seattle, WA 98104

Date: _____

To Whom It May Concern:

I am applying for a license to practice dentistry in the state of Washington. Please send this form directly to the Dental Quality Assurance Commission Credentialing.

Applicant Printed Name: _____

Date of birth: _____

DEA Registration Number: _____

DEA Registration Number: _____

DEA Registration Number: _____

DEA Registration Number: _____

If you have additional DEA Registration Numbers, please attach another form.

Applicant's signature _____

To be completed by the Drug Enforcement Administration:

Applicant has surrendered (for cause) or had a federal controlled substance registration revoked, suspended, restricted, or denied. Yes No

Initials _____ Date _____

Please mail this completed form to the Dental Quality Assurance Commission Credentialing Section at the address listed above, or you can email it to:

hsqlacredialreview@doh.wa.gov.