Washington State Department of Health

Physician Initial License Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360-236-2750 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

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:

Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866

Contact us:

360-236-2750

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Washington State Department of Health

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. Please call the Customer Service Center at 360-236-2750 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.

Birth place: Provide the city, state, and country where 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, Fax, and Cell Numbers: Enter your phone, fax, 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 5 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. Medical Education and Postgraduate Training:**
List in chronological order your medical school education. Verify all accredited postgraduate training received in the United States or Canada. Verification must be completed by the program director with beginning and ending dates and sent directly to the Medical Commission.

Note:

- If you graduated from medical school before July 28, 1985, one year of postgraduate training in the United States or Canada is required, **or**
- After July 28, 1985, two years of postgraduate training in the United States or Canada are required.

☐ **4. Professional Experience:**
List in chronological order any professional experiences you have had since medical school. A Curriculum Vitae or resume will not be accepted in lieu of completing this section of the application. If you need more space, attach a piece of paper.

☐ **5. Hospital Privileges:** (Excluding postgraduate training)
List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five years. If you need more space, attach a piece of paper.

- Verifications must be received directly from each hospital. This does not include postgraduate training hospitals.
- Verification for military hospital privileges may be obtained by the current duty station or, if no longer in active service, National Personnel Records Center, Military Personnel Records, 1 Archives Dr, St Louis MO 63138.
- Locum Tenens: Hospital privileges of a 30-day or longer duration.

☐ **6. Licenses in Other States:**
List all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. List in date order, starting with the most current. If you need more space, attach a piece of paper. Please provide verification directly from the state(s) that you have listed in this section.

☐ **7. AIDS Education and Training Attestation:**
AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training, required by **WAC 246-12-260** course content can be found at **WAC 246-12-270**. If AIDS education was included in your professional education or training, an additional course is not required.

☐ **8. Applicant's Photograph:**
Attach a current photograph in the box provided or attach to the application. Indicate the date the photograph was taken. Sign in ink across the bottom of the photo. The photograph must be a clear, close up, with a front view of applicant.

☐ **9. 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.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

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Washington State Department of Health

License Requirements

Federation of State Medical Boards (FSMB) Uniform Application Option: The Commission is in the process of accepting applications through the FSMB Uniform Application. For additional information, and to check for Washington availability, along with the Uniform Application please visit the **FSMB website**.

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, board action history, board certification and identity. For more information, please visit the **FCVS website**.

☐ **Medical School Transcripts:**
Official transcripts must be sent directly from the applicant's medical school to this office listing the dates of attendance, subjects completed, degree and date awarded.

☐ **Medical License Examination Requirements:**

- Any applicant graduating from medical school after October 11, 1993 must take and pass all steps of the United States Medical License Examination (USMLE) or the Licentiate of the Medical Council of Canada (LMCC).
- Any applicant graduating from medical school before October 11, 1993, and using a state or territory license examination as their qualifying examination will be considered on a case-by-case basis. These applicants are also required to obtain the Examination and Board Action History Report (EBHAR) sent directly from FSMB. The EBAHR may be ordered **online** at or by calling 817-867-4000.

Official license examination certification must be sent directly from the office of record. Applicants must have received a score of at least 75. The commission reserves the right to request any applicant to take additional examinations:

- USMLE or FLEX scores must be received directly from the Federation of State Medical Boards. You can obtain the request form through their **website**. If you have difficulty accessing the form, you can contact the FSMB at (817) 868-4041.
- National board scores must be received directly from the National Board of Medical Examiners. You can obtain the request form through their **website**. If you have difficulty accessing the form, you can contact the NBME at (215) 590-9592.
- LMCC must be received directly from the Medical Council of Canada, Le Conseil Medical du Canada, 2283, bl. St. Laurent Blvd., Suite 300, Ottawa, Ontario K1G 5A2, phone (613) 521-6012. A valid certificate must have been obtained after 1969.
- State examinations scores sent directly from the state medical board.

☐ **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 or Fifth Pathway:**
In addition to the standard requirements previously stated, international medical graduates must also submit one of the following:

- 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. Pursuant to **WAC 246-919-340**, ECFMG

  Certification is not required if the applicant was issued a physician license in the United States prior to 1958 or completed a Fifth Pathway program (see below). The request for certification can be obtained through the **ECFMG's website**.

- Fifth Pathway Applicants: The AMA defines a pathway as an approved avenue to residency training at a U.S. hospital that completes a medical student's education. There are five path ways:

  1. Graduation from a U.S. medical school
  2. Certification by the ECFMG – Educational Council for Foreign Medical Graduates
  3. Full and unrestricted licensure by a U.S. licensing jurisdiction
  4. Passing the Spanish language licensing examination in Puerto Rico
  5. Fifth Pathway program – as of 1971.

- The following are the official pathway programs:

  1. New York Medical College, which has the longest continuous program since 1974.
  2. Ponce School of Medicine – Ponce, Puerto Rico
  3. Mt. Sinai Hospital – New York – as of January 2007

Fifth Pathway applicants must submit evidence of successful completion of an accredited program.

- Dates of attendance and evaluations are to be sent directly from the program. The postgraduate training verification form may be used.
- All documents not written in English must be translated. This may be done by a professional U.S. translating agency, consulate, the school program (using letterhead stationary), or a qualified recognized translator. All translations must be original documents with the appropriate signatures and seals. They must be accompanied by a certified copy of the documents being translated. Original translations will be returned to the applicant if certified copies of the translations are also submitted.

A **temporary permit** can be issued if the applicant:

- Has been previously licensed from a recognized jurisdiction (listed on page two of the request form).

Applicants who have not practiced clinical medicine for at least two years. If an applicant has **not practiced clinical medicine for two or more years**, the Commission may require the applicant to do one or more of the following:

- Pass the Federation of State Medical Boards Special Purpose Examination (SPEX). You can contact them at (817) 868-4000 or visit their website at **www.fsmb.org**.
- Undergo a knowledge and skills assessment at The Center for Personalized Education for Physicians CPEP (303) 750-7150 or **www.cpepdoc.org**.
- Undergo a knowledge and skills assessment at the University of California at San Diego School of Medicine, Physician Assessment and Clinical Education Program (PACE) (619) 543-6770 or **http://www.paceprogram.ucsd.edu/**.
- Successfully complete an additional year or more of post-training, accredited through the Accreditation Council for Graduate Medical Education, and pre-approved by the Commission.
- Complete any other examination or assessment the Commission deems appropriate.

Once the Commission requests an applicant to complete one of these requirements, the Commission will not permit the applicant to withdraw the application. If the applicant does not successfully comply with the Commission's request to complete one of the above items, the Commission may deny the application.

After the application and fees have been received by the department, the applicant will be notified if any documents or data are missing.

- Applicants should allow a minimum of 8-16 weeks for processing. Only complete applications will be considered for review.
- Routine applications require five days for processing. Non-routine applications require more time for processing.
- All information, documents, data, etc. provided to the department by the applicant will become a part of the file.
- It is the responsibility of the applicant to submit the correct forms to the appropriate entities to obtain 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.
- Copies of transcripts, postgraduate certificates, licenses, hospital privileges, and examination scores, will not be accepted.
- Applications that are pending for one year will become invalid, along with the fee and any other supporting documentation. After that time, it will be necessary to begin the process over with a new application, current fee, and all supporting documents.

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Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue 0252090000

Medical Practice License Application for MDs only

☐ National Boards ☐ Other State Exam ☐ LMCC (Must have been obtained after 1969)
☐ Flex Examination ☐ USMLE Examination

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

Name	First	Middle	Last

Birth date (mm/dd/yyyy)	**Place of birth**		
	City	State	Country

Address			
City	State	Zip Code	County
Country			

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

Email address

Mailing address if different from above address of record

City	State	Zip Code	County
Country			

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):

Medical Speciality

Medical school	Year of Graduation
Medical Specialty	

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ..... ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

   Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

   The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain ..... ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ..... ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ..... ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

   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. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ... ☐ ☐

   Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

   To protect the public, the department considers criminal history. 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.

2. Personal Data Questions (Cont.)

	Yes	No
6. Have you ever been found in any civil, administrative or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☐
b. Diverted controlled substances or legend drugs?	☐	☐
c. Violated any drug law?	☐	☐
d. Prescribed controlled substances for yourself?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all judgments, decisions, and agreements?	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐
11. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?	☐	☐
12. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?.	☐	☐
13. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?.	☐	☐
14. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?.	☐	☐
15. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?	☐	☐

3. Medical Education and Postgraduate Training

Provide a date listing of your educational preparation and postgraduate training. If you need more space, attach a piece of paper.

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.)	Number of years attended	Dates granted	
			Start mm/yyyy	End mm/yyyy
Medical education (list all medical schools attended)				
Postgraduate training (list all programs attended)				

4. Professional Experience

In date order list all professional experience received since graduation from medical school to the present. Exclude activities listed under other sections, identify any periods of time break of 30 days or more. If you need more space, attach a piece of paper.

Name and location of institution	From (mm/dd/yyyy	To (mm/dd/yyyy	Nature of experience or specialty

5. Hospital Privileges (Excluding postgraduate training hospital privileges.)

Excluding postgraduate training, list hospitals where all privileges that have been granted within the past five years. If you need more space, attach a piece of paper.

Name of hospital	Dates attended	
	Start date mm/dd/yyyy	End date mm/dd/yyyy

6. Licenses in Other States

List all licenses to practice medicine in any state, territory, Canadian province or other country. Include active, inactive, temporary and training licenses. Please provide verification directly from the state(s) that you have listed in this section.

State	Date license issued	License Number	Status of license	Any limitations on license
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes

7. AIDS Education and Training Attestation

I certify that I have completed a minimum of four hours of education in the prevention, transmission, and treatment of AIDS. This education included topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

If AIDS education was included in your professional education or training, an additional course is not required.

Applicant's initials	Date

8. Applicant's Photograph

Photo Here

Attach current photograph here. Indicate date taken and sign in ink across bottom of the photo.

NOTE: Photograph **must** be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view of applicant

Height _____

Weight _____

Hair color _____

Color of eyes _____

Signature _____

Date of Photo _____

9. 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)

Washington State Department of Health

Temporary Permit Request

I hereby request a **one time only temporary permit**. I understand that the temporary permit shall expire upon the issuance of a full license, initiation of an investigation by the commission, or 90 days, whichever occurs first.

Signature _____ Date _____

Print or type full name _____ Date of birth _____

Mailing address _____

City _____ State _____ Zip Code _____

Note: Fees submitted with application for initial credentialing, examinations, renewal, and other fees associated with the licensing and regulation of the profession are non-refundable. See **WAC 246-12-340**.

General Information

Must be licensed in a recognized jurisdiction. See list on page two.

A temporary permit may be issued upon receipt of the following:

1. Completed application form.
   a. If any personal data questions 1-15 have a positive answer, it has to be reviewed by the commission's designee.
2. Temporary permit request form.
3. Application and temporary permit fees paid.
4. A clear Federation of State Medical Boards (FSMB) data bank clearance report.
5. A clear American Medical Association Profile.
6. Written verification from ALL states in which the applicant was or is licensed.

For Office use only

☐ Approved

☐ Disapproved

Review date _____

Signature _____

General Information on Recognized Jurisdictions

Jurisdictions with licensing standards substantially the same as Washington's standards, for postgraduate training requirements are set out below.

If you are a US/Canadian physician who graduated before July 28, 1985 (requirement of 1 year of postgraduate medical training), you must have a license in one of the following states:

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Guam
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Texas
Utah
Vermont
Virginia
West Virginia
Wisconsin
Wyoming

If you are a US/Canadian physician who graduated after July 28, 1985 (requirement of 2 years of postgraduate medical training), you must have a license in one of the following states:

Connecticut
New Hampshire
Maine
Michigan
Nevada

If you are a foreign medical graduate who graduated before July 28, 1985 (requirement of 1 year of postgraduate medical training and ECFMG certification), you must have a license in one of the following states:

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Guam
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
West Virginia
Wisconsin
Wyoming

If you are a foreign medical graduate who graduated after July 28, 1985 (requirement of 2 years of postgraduate medical training and ECFMG certification), you must have a license in one of the following states:

Arizona
Colorado
Connecticut
Delaware
Georgia
Hawaii
Idaho
Indiana
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oregon
Rhode Island
Tennessee
Texas
Virginia
West Virginia
Wyoming

Washington State Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360-236-2750

MD

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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Washington State Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360-236-2750

MD

Postgraduate Training Program Director Verification and Evaluation of Training

To be completed by the applicant:

Facility name _____

Address _____

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 the postgraduate training performed 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 below. **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:

1. _____ is or was engaged in postgraduate training in our
   Applicant Name (Print or type)
   program_____

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

   in the field of _____
2. At the time this individual was in training, was this program accredited through the accreditation council for graduate medical education, the Royal College of Physicians and Surgeons, or the college of family Physicians of Canada? ☐ Yes ☐ No
   If no, does this program qualify the applicant to become board certified? ☐ Yes ☐ No
3. Was the participant ever placed on probation, restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? ☐ Yes ☐ No

   If yes, please explain _____
4. Did this applicant successfully complete this training program? ☐ Yes ☐ No
   ☐ in process OR ☐ expected date of completion _____

(SEAL)

Signature _____

Title _____

Email _____

Address _____

_____

Return to address listed above

Date _____ Phone_____

(This page intentionally left blank.)

Washington State Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
360-236-2750

MD

Hospital Privileges Verification

(Excluding postgraduate training hospital privileges)

To be completed by the applicant:

Hospital Name _____

Address _____

I am applying for a license to practice medicine 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 or type)	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 or type)

   this hospital from _____ to _____.
   (mm/yyyy) (mm/yyyy)

2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?

   ☐ Yes ☐ No If yes, please explain _____

   _____

3. Has the applicant ever been asked to resign? ☐ Yes ☐ No If yes, please explain _____

   _____

4. Did the applicant ever resign in lieu of or to avoid adverse action? ☐ Yes ☐ No If yes, please explain

   _____

5. Has a report concerning the applicant ever been sent to the National Practitioner Data Bank or the Health Care Integrity and Protection Data Bank by this hospital? ☐ Yes ☐ No

(SEAL)

Signature _____

Title _____

Email _____

Address _____

Return to address listed above.

_____

Date _____ Phone _____

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Washington State Department of Health

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

Physician, WAC 246-919

Physician fees and renewal cycle. Licenses must be renewed every two years on the practitioner's birthday. See WAC 246-919-990

How to obtain an initial credential. The initial credential will expire on the practitioner's birthday. Initial credentials issued within ninety days of the practitioner's birthday do not expire until the practitioner's next birthday. See WAC 246-12-020(3)

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

Continuing Education

Physician Continuing Education Rules, WAC 246-919-460

Online

Medical Quality Assurance Commission, Web Page